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ABSTRACT

This text is directed toward service providers, advocacy groups, administrators, and other interested parties who are given the task of setting up independent living facilities for the developmentally disabled. Emphasis is placed on the group home concept of alternative living arrangements. Chapter 1 considers models for alternative residential facilities. Staff patterns and types of independent living are described. Chapter 2 discusses federal programs available for alternative community living models, including Medicaid, intermediate care facilities (ICF), supplemental security income, and Title XX. Chapter 3 addresses planning and locating community-based living facilities. Topics are assessment of the local housing market, funding sources, zoning regulations, and strategies for overcoming restrictive zoning. In chapter 4 the focus is on accessibility considerations and safety. Chapter 5 describes the legal rights of all citizens, including the handicapped, and provides information on standards for quality programming from the Accreditation Council for Mentally Retarded and Other Developmentally Disabled Persons, and ICF for the Mentally Retarded rules and regulations. Case management is also discussed. An outline for a staff training program is provided in the final chapter. Appendixes include an annotated bibliography, sample fire-safety code regulations, and state agency addresses for sources of further information on independent living. (YLB)

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PLANNING AND OPERATING GROUP HOMES
FOR THE
HANDICAPPED

Grace Strano Youngblood

Gerard J. Bensberg, Ph.D.

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Introduction

The deinstitutionalization of our disabled citizens is on the move today. Returning institutionalized individuals to the community requires residential environments that protect human and civil rights as well as promote normal community living. Concerned groups are faced with the task of finding suitable alternative living situations that enable the handicapped to live as normal a life-style as possible. Such a task can at times seem overwhelming and often frustrating.

The text is directed toward service providers, advocacy groups, administrators, and other interested parties who are given the task of setting up independent living facilities for the developmentally disabled. The book is practical in application with emphasis placed on the group home concept of alternative living arrangements.

The text consists of six chapters that detail important areas of concern the service provider will more than likely have to deal with as he attempts to set up group homes for his clients. These areas include funding sources, zoning regulations, strategies for overcoming restrictive zoning, ICF/MR rules and regulations, AC MRDD standards for quality programming, staff training and orientation, model facilities and supervision, staffing patterns, staff/tenant relationships, housing considerations, accessibility consideratins, community resistance and acceptance, the law's effects through legislative and court rulings, etc. The appendices include an annotated bibliography, sample fire-safety code regulations, and state agency addresses for further sources of information on the independent living movement.

Table of Contents

Chapter I

Determination of Models for Alternative Residential Facilities

Staff Patterns 1
Range of Models 8

Chapter II

Federal Programs Available for Alternative Community Living Models

Medicaid 19
Intermediate Care Facilities 22
Certificate of Need 28
Supplemental Security Income 30
Title XX 35

Chapter III

Planning and Locating Community-Based Living Facilities

Assessing the Local Housing Market 43
Available Funds for Residential Facilities 46
Zoning for Alternative Living Facilities 55
Strategies for Overcoming Restrictive Zoning 69

Chapter IV

Determination of Population Needs

Federal Standards for Accessibility 77
Accessible Features and Design Considerations 82
Home Safety - Life Safety Code 91

Chapter V

Development of Policies and Procedures

Client's Rights 99
AC MRDD 113
ICF/MR 123
Case Management 142

Chapter VI

Programmatic Matters

Introduction 153
Training Program and Resources 157

Bibliography

Appendices

Appendix A

Annotated Bibliography....................................217

Appendix B

Life Safety Code..233

Appendix C

State Agency Directory....................................257

CHAPTER I

Determination of Models for Alternative Residential Facilities

Staff Patterns

Like most other components of the residential program, staffing patterns vary from state to state with most patterns based on the philosophy of the sponsoring agency and the size of the program. Examples of the many types of patterns include: young married couples functioning as houseparents, three or more single individuals serving as housemanagers, professional staff filling specialized roles, individuals serving as a foster family, group homes operated for older adults, staff members working and living with retarded people as a result of a spiritual commitment, or retired individuals or couples working as staff.[1]

A comprehensive, national study on community residential facilties (1976) found two distinct CRF staff patterns. The first and most predominant pattern appears to be a full time director with additional staff. Typically, the director is responsible for planning and managing the administrative and programmatic operations of the residential program. The additional staff are responsible for resident supervision, care, training, recreation, and facility operation and maintenance.[2]

Under Lubbock's Alternative Community Living Program, the director performs administrative duties related to coordinating service programs for the residents. Specific examples of the director's tasks include:

1. Supervision and coordination of all MR programs.
2. Monitoring and consulting with contract agencies.
3. Maintaining contact and communication with other community agencies to develop an awareness of community programs available to the residents under a particular program.

4. Securing financial resources of new services for the clients.

5. Evaluating all job performances of MR service personnel.

Additional staff under this program includes administrative technicians who serve as unit coordinators, houseparents who are employed on three, eight hour shifts and are generally responsible for carrying out household activities and training clients, and trainers who assist houseparents in training clients in daily living skills.

The second pattern, and perhaps the most ideal, is designed to accommodate "live-in" houseparents. Houseparents in this model deal with a host of responsibilities, including administrative, management, and operational duties. However, their main task is to provide the client with a homelike, normal atmosphere. In many states, they work closely with a Unit Coordinator who administers and directs activities and programming on a 24 hour basis. For example, houseparents in the Fort Worth State School area assist the Unit Coordinator in decisions on implementing clients' individual program plans (IPP). Other tasks include the following:

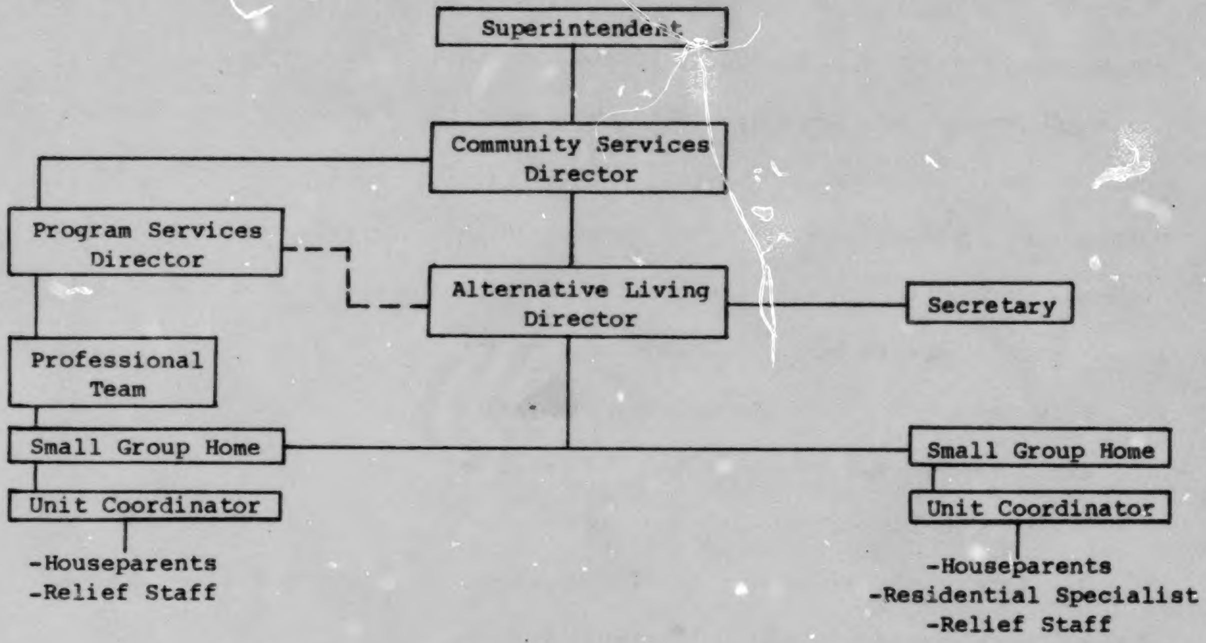
1. Provide clients with socialization skills.
2. Complete a medication course to become a certified medication aide in order to administer and document medications as directed by a physician or nurse.
3. Order, prepare, and serve food to the clients daily.
4. Train the clients in specific areas of IPP's (i.e., table setting, table manners, bed-making, laundering, cooking, shopping, money management, etc.).
5. Establish and execute recreational programs for the clients.
6. Coordinate program activities and maintain open channels of communication with the client's parents.
7. Assist the Unit Coordinator in training relief houseparents. (Relief houseparents are hired usually on weekends to give the regular staff time off).

Hypothetically, a group home model may accommodate eight mentally retarded adult women and 2 single female staff members who live in the home. One of the staff members has considerable teaching experience with the handicapped and considers her job as houseparent full-time. The other staff member has worked with state agencies prior to becoming a house parent. She runs her own business during the day when the residents are at their day activities. A relief staff comes in on the weekends to give the regular staff time off. Such a live-in pattern provides the following advantages:

1. a more normal home life for the residents.
2. more consistent results when behavior modification techniques are used.
3. more psychological/emotional support for the residents.
4. higher staff-to-resident interaction.
5. closer client supervision.
6. role models for the residents.

The success of staff placement in residential settings for the mentally retarded appears to be based on one sound foundation - communication. Too often in the past lines of communication among the various levels of authority have been blurred due to struggles for power and independence. Unfortunately, such situations have been a major cause of high staff turnover.

An example of lines of authority within a typical administrative setting may entail the following graphic illustration:



In this arrangement, house parents are directly responsible to the Alternative Living Director. Ideally, houseparents should be a part of the disciplinary team who provide services (i.e. medical, dental, etc.) to the clients. The reasoning behind this idea is that houseparents know first hand what the needs of the residents are and can provide valuable input to the team of professionals.

For those staff members living with residents, adjustment is often difficult. One major problem encountered by houseparents is a stress factor due to frustrations in communicating with state agencies, particularly in regard to regulations and policies. For example, many houseparents feel they have little or no input about decisions concerning client placement in group homes. They believe their input in this area would be of great value to administrators because of their daily interaction with clients.

Dealing with the various levels of mental retardation and client age within the same residential setting is another common problem houseparents find. Older clients not only slow down the younger residents, but they also have more emotional problems, are often harder to train, and have less experience with independent living than younger residents. As a result, houseparents find they must "change gears" when dealing with individual clients.

A majority of complaints voiced by the staff in small group homes dealt with a lack of privacy and "no time for oneself." This is particularly true of young married couples. According to Baker et al., several community residence directors and many single relief persons repeatedly elaborated on the problems of hiring married couples, particularly young married couples, as houseparents.[3] The problems included:

1. If the houseparents' relationship is unstable, it creates a tense atmosphere in the community residence.
2. When the houseparents quit or are fired, or if they go on vacation, suddenly the community residence is left with most, if not all, its staff gone.
3. Typically, the wife works full-time while the husband attends school or works elsewhere during the day. There have been several cases in which the husband's interest in the community residence was minimal, and the wife in actuality, performed both their functions.

Other problems that have been brought to the attention of service providers in hiring live-in staff include:

1. extremely low pay.
2. high staff turnover due to "burnout" from constant interaction with the residents.
3. client dependency on staff members which is not conducive to the philosophy of independent living.
4. lack of quality training, resulting in little knowledge of the client's needs in learning independent living skills.
5. lack of clearly defined staff roles (i.e., should the staff teach, counsel, or act as substitute parents?).

Staff turnover in small group homes occurs, on the average, once every two years. Houseparents feel that minimal living space, no other home to "retreat" to, and constant supervision of the residents have greatly contributed

12

to such a high turnover rate. A married couple who work as houseparents in a small group home for children in Fort Worth maintain their own home as a "weekend retreat" when the relief staff come on duty. This particular couple felt that they needed time alone in another setting with their own children. The wife felt that because she and her husband had to provide more attention to the other children, their own children were being neglected. Their solution was to maintain another house separate from the group home.

According to Baker et al., the small group home's staffing pattern insures a short-term institutionalization of staff who live and work at the same place even as it attempts to deinstitutionalize the residents.[4] The result is high staff turnover. Most studies indicate that, proportionally, the turnover rate in small group homes is significantly higher than in larger facilities and institutions.

Various programs have experimented with "trial and error" staffing patterns in an attempt to alleviate the high turnover problem. For instance, administrators in Fort Worth were faced with the problem of hiring individuals or couples to work at Wedgewood during the same hours as those of professionals (i.e., doctors, dentists, etc.) so that the clients could take advantage of their services. Married houseparents were originally hired on a 24 hour basis. When it was found that this staff pattern was not the most ideal, the staffing was reorganized to include one staff member who would come on duty during the hours that their clients needed professional services and a training staff would take over after normal working hours. Again, problems arose with this particular reorganization and they finally hired two full-time, live-in females. Both staff members are responsible for making sure that the clients are provided with the necessary services as well as training them in independent living skills.

An example that has proven successful is the housemanager pattern in which approximately three single, unrelated people replace the traditional houseparent design. Each has specifically defined roles so that all of the residents' needs can be dealt with rather than ignored. Baker et al., found that because houseparents' roles tend to be so generalized, residents do not learn new skills, have their emotional needs satisfied, or integrate successfully into the community. The houseparents simply can not deal intensively with any one need without ignoring the others.[5] The housemanager pattern appears more successful as their roles are specifically defined. In conjunction with this pattern, auxiliary, specialized staff are established to take care of those needs the housemanagers can not satisfy.

Ideally, the residential program should be divided into three major functions as is done in Georgia's Division of Mental Health and Mental Retardation. They view their Independent Group Resident Program as divided into a home life function, a program support function and an administrative function. Each component is separate and distinct, yet they are interrelated and supportive of each other. The objective of the program is to maintain visibility of each function so that staff roles do not become confused, thus avoiding high staff turnover and discontinuity for the residents. Their philosophical orientation in patterning their staff directly relates to these functions:[6]

> Eminating from the home function is the goal of providing a stable home environment for...people for an indefinite period of time. The stability of the home is made possible by a "live-in" staff member (home manager) whose basic role is to support (to whatever degree necessary) the home like qualities of the program. The home has programmatic support by having staff (auxiliary staff) whose primary job is to provide training and supervision when and where residents need it. By assuming many of the duties for training and supervision, the auxiliary staff permit the live-in staff member the freedom not to be programmatic but rather to act as a support house member. This is central to the clarity of the Independent Group Residence, as live-in staff have traditionally been expected to "be everything to everybody." Finally, the home is supported administratively by a program

director who is responsible for balancing off all of the competing interests of staff, goals, policies, etc., to support the Independent Group Residence in a way which allows residents to be served appropriately in their home.

Range of Models

The major goal of residential programs is the successful placement of residents into the mainstream of society. To meet this goal, various models of residential settings that range in levels of supervision and care have come into existence. According to Lawder et al. (1974), careful thought must be given to service goals and certain generic components in designing models and developing programs to fit these models. For instance, the service provider must consider the following factors:[7]

1. the age of the child (or adult) to be served, his problem, his parental situation.
2. anticipated length of time in care.
3. intensity of social and psychological treatment envisioned.
4. kind of environment...needed.

Based on programmatic components and orientation to independent living, models do vary from state to state. However, there are four basic types, and variations thereof, that will be considered in this section:

Family Homes
Apartments - Single Family Dwellings
Small Group Homes
Specialized Medical Facilities

Family Homes

The natural home is by far the least restrictive environment for the infant, child, or adolescent who is mentally retarded. However, for those individuals who require constant care because of medical or behavioral problems, the natural home may not be equipped or staffed to provide this type of supervision.

For those individuals who cannot return to their natural home, an adoptive type home may be the next best alternative. Legal guardians can provide the type of normal family life and parental role models often needed by clients who have developmental disabilities. Foster home care is another alternative and is classified as legal, temporary or long-term custody of infants, children or adolescents. Foster homes can also provide the client with the type of home life which is condusive to a stable environment. However, foster care is considered a short-term residential placement setting as opposed to either the natural home or the adoptive home.

The Texas Association for Retarded Citizens (1980) devised a list of crucial services for clients who are placed in family homes:[8]

1. Food and Nutrition Services
2. Speech and Hearing Therapy
3. Toilet Training
4. Developmental Training
5. Baby Sitting
6. Respite Care
7. Parent Training
8. Social Services
9. Financial Assistance
10. Physical Therapy
11. Occupational Therapy
12. Health Care
13. Legal Assistance
14. Sex Education
15. Information and Referral
16. Educational Services
17. Special Equipment

Apartments - Single Family Dwellings

For older clients (18 years +), independent living in an apartment situation or a single family dwelling is the preferred residential placement. Here, clients are more or less on their own, utilizing the skills they received in a more traditional setting. Usually, they will share their living arrangements with no more than three other residents. Services are minimal and occasionally a social worker or support staff member will schedual follow-up visits. Those services that are provided might include: social services, information and referral, financial assistance, physical therapy, occupational therapy, legal assistance, health care, vocational training and placement, religious nurture, and sex education/family planning.

Depending on the level of supervision needed, apartments and single family dwellings can also accommodate individuals who require more frequent visits and additional services from staff members to help with self-care needs and additional training in areas in which they may be less proficient.

Nebraska's residential programs are based on a regional service model which provides more individualized services than most other programs which incorporate regional center models. These regional center models provide a wide range of services that are in close proximity to the residences. According to Fritz et al. (1971), this type of service model perpetuates institutionalization on a smaller scale in that services are provided to large groups residing together and, thus, fail to integrate their residents into the mainstream of their communities.[9]

In keeping with the regional service model orientation, the Nebraska plan for the development of apartments includes three broad categories:[10]

1. Apartment Clusters - composed of several apartments in relative physical proximity, functioning to some extent as a unit, and supervised by staff members who reside in one of these apartments. Here, the degree of supervision depends on a number of factors including: how close the apartments are to each other, staff-to-resident ratio and interaction (as dictated by individual needs), and the actual types of services needed by the residents.
2. Co-residence Apartments - occupied by one or two adult staff members and two or three retarded persons living together as roommates or friends. In this set-up, ideally, the staff member's role is to provide "friendly guidance" and the residence itself should foster as much self-sufficiency on the part of the resident as possible, with the goal being to eventually eliminate the client's need for a live-in staff.

3. Maximum Independent Apartments - occupied by two to four retarded adults and requiring little, if any, supervision or assistance in physical or social skill training (i.e., money management, food shopping, leisure time activities, etc.).

Group Homes

The group home design is the model most widely used to promote independent living. The Federal agency of the Administration on Developmental Disabilities provides a comprehensive definition pursuant to 1967 rules and regulations related to the establishment of group homes (WAC 275.36.010):[11]

-A group home is a residential facility capable of serving, among others, a small number of mentally retarded and/or physically handicapped individuals-up to a maximum of 20- who are able to participate in a variety of jobs, sheltered workshops, day care centers, activity centers, educational facilities, and/or other community based programs that are meaningful for their training, rehabilitation, and/or general well-being.

-A group home is usually a single dwelling, a series of apartments, or other buildings with sound structure which shall offer a pleasant and healthful environment for human life and welfare. The building for a group home may be owned or leased, a house or apartments, or a segment of a larger facility.

-Group homes must be located within reasonable proximity to those community resources that are necessary adjuncts to a training or education and/or rehabilitation program.

-Living quarters shall emulate a home-like atmosphere and the residents will take part, insofar as they are capable, in their own personal care and in the care of their quarters.

-A group home may be an extension of programs of existing residential facilities serving mentally and physically handicapped individuals and will be viewed as an element in a comprehensive plan for mental retardation services in a region.

There are two basic types of group homes in operation: transitional group homes and long-term group homes. Depending on a state's program, staffing patterns range from live-in houseparents to housemanagers and/ or supervisory professional staff members. The residences are primarily designed to house six to eight children or adults. The transitional homes are designed to house persons 18 years or older with the intention that the individual will move on to a less restrictive residence (i.e., apartment living) after mastering independent living skills. The long-range group homes are more permanent residences for those individuals who show less ability in living independently. However, many long-term group homes are programmed and operated to allow those who progress the opportunity to move on to less restrictive environments.

Group homes do exist that have highly specialized programs, facilities and equipment for such clients as the multiply handicapped retarded person, the mentally ill retarded individual, the mentally retarded offender - those individuals who require services "above and beyond" the basic services available in the transitional or long-term group home programs.

A list of services for group homes might include the following:[12]

1. Social Services
2. Information and Referral
3. Financial Assistance
4. Social Rehabilitation

11. Speech and Hearing Therapy
12. Legal Assistance
13. Recreation
14. Paraprofessional Counseling

5. Dietary Services
6. Transportation
7. Behavioral Modification
8. Toilet Training
9. Physical Therapy
10. Occupational Therapy
15. Advocacy
16. Health Care
17. Religious Nurture
18. Sex Education/Family Planning

Medical Facilities

There are temporary facilities in existence for persons who are mentally retarded with medical conditions that require constant 24 hour care and treatment. Known as Transitional Skilled Nursing Homes, such residences provide the following services:[13]

1. Medical Services
2. Dental Services
3. Educational Services
4. Dietary Services
5. Library Services
6. Nursing Services
7. Pharmacy Services
8. Physical Therapy
9. Financial Assistance
10. Transportation
11. Behavioral Modification
12. Paraprofessional Counseling
13. Occupational Therapy
14. Speech and Hearing Therapy
15. Psychological Services
16. Recreation Services
17. Religious Services
18. Social Services
19. Information and Referral
20. Advocacy
21. Social Rehabilitation
22. Toilet Training
23. Legal Services
24. Sex Education/Family Planning

It should be emphasized that these skilled nursing homes should be viewed as temporary and most of the indviduals who reside in such facilities are there for illnesses and disabilities that require daily medical care and supervision by medically trained staff members.

Other Models

There are several other types of residential facilities that should be mentioned at this point. They include the halfway house, boarding homes, hostels, nursing homes, intermittent or respite care units, and community residential training units.

Halfway House

The halfway house is programmed and operated as an alternative between institutional living and independent community living. A halfway house is defined as a temporary home for adults who need to make a transition from institutional life to community living.[14] Originally established for the mentally ill, these facilities have now become suitable for the mentally retarded. They can house a small group of residents or accommodate anywhere from 25 to 30 individuals.

Boarding Homes

Boarding homes are highly autonomous in that the resident is essentially left on his own as no type of supervision, recreation, and personal attention is provided by boarding home operators. They are set-up to house mentally retarded adults and provide only room and board. Cost is relatively low and the residents can usually get by with their own earnings, parent's assistance, or public welfare assistance.

Hostels

Often equated with the group home design, hostels are defined as a place of permanent residence for a small group of approximately 15 to 40 mentally retarded men and women over 17 years of age, who are able to participate in a variety of community jobs or programs during the work day. A hostel is usually a single dwelling or series of apartments and not part of an institutional campus. Living quarters will have a homelike atmosphere. Residents will participate in all aspects of their living situation and personal care as far as they are capable.[15]

The above definition of a hostel is based on the New York State plan for residential facilities. The main difference between this particular design and a halfway house is that a hostel provides permanent residency. The resident in a halfway house can move on to more independent, less supervised living arrangements.

Nursing Homes

Nursing homes are set-up to provide ongoing nursing care to individuals who have physical problems, chronic illnesses, or disabilities in addition to mental retardation.

Intermittent or Respite Care Units

Respite care units are temporary shelters or foster care homes (i.e., Northern Virginia plan) that serve all age groups and all degrees of handicaps. This particular program is more of a service set-up to allow families who have retarded members occasional relief or time away from the care of the mentally retarded person.[16]

Community Residential Training Unit

A Community Residential Training Unit is a type of living arrangement set-up on a five-day/weekend planned program for ambulatory, severely and profoundly retarded individuals. Haven Home in Pittsburg, Pennsylvania is an example of this type of facility in which eight retarded children between the ages of three and eight live at the facility during the week and return home on the weekends. Eight other retarded children move in on the weekends for the same program. The program is set-up to allow the children to participate in educational, occupational, physical, and speech therapy programs. Focus is given to improving adaptive behavior, developing language skills, establishing appropriate social behavior, and self-help skills.[17]

Most states vary in the types of residential programs available for the developmentally disabled. However, the basic philosophies of the programs are similar in terms of community placement. The advantages of independent living are numerous and make community placement a highly desirable alternative to institutionalization. Mamula and Newman (1973) list a few of these advantages as follows:[18]

1. Community placement offers increased opportunities for normal social development through daily interaction with normal individuals by delaying separation from the community at large.

2. Because of the small size of community placement facilities, the person who is mentally retarded can be afforded individual attention and affection which would be prohibitive in a large institutional setting...(and) can also contribute to more rapid growth and development as a result of participation as a family member in a family type atmosphere not to dissimilar to that from which he came.

3. Community placement enables the community to become more accustomed to relating to the mentally retarded...

4. Community placement tends to sustain the chance of eventually reuniting the family when the natural family is intact or able to be rehabilitated.

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CHAPTER II

Federal Programs Available for Alternative Community Living Models

Medicaid

Federally supported services for the medically indigent began as a direct result of the Great Depression in the 1930's. What formerly was considered the family's responsibility for their medical needs became the responsibility of the government as dictated by economic and social forces.

In 1935, the Social Security Act was passed and federal funds provided recipients of public assistance with direct cash payments. After a series of amendments spanning more than 20 years, a Medicare-Medicaid bill was introduced in Congress in 1965. Public Law 89-97 was signed by President Lyndon Johnson that same year and the Medicaid portion of the bill became effective January 1, 1966. Medicare followed six months later.

Authorized under Title XIX, Medicaid became a major source of funding for alternative care facility services. The Medicaid program is based on a federal/state sharing formula. Medicaid provides funds for medical assistance based on state plans. Each state is responsible for 17% to 50% of the total costs of the program. The federal government provides a share ranging from 50% to 83% of the total costs.[1]

The following is a list of services provided by the Medicaid program:

1. Inpatient Hospital Services
2. Outpatient Hospital Services
3. Other Laboratory and X-ray Services
4. Skilled Nursing Facilities for Individuals 21 years or older
5. Physician's Services
6. Medical Care and Remedial Care

7. Home Health Care Services

8. Private Duty Nursing Services

9. Clinic Services

10. Dental Services

11. Physical Therapy, Occupational Therapy, and Treatment of Speech and Hearing Disorders

12. Prescribed Drugs, Dentures, Prosthetic Services or Eyeglasses

13. Other Diagnostic, Screening, Prevention and Rehabilitative Services

14. Inpatient Hospital Services, Skilled Nursing Facilities Services and Intermediate Care Facility Services for Individuals 65 years of age or older in an Institution for Tuberculosis or Mental Disease

15. EPSDT - Early and Periodic Screening, Diagnosis and Treatment for Children

Under the Medicaid program, payment is made directly to medical care providers through a single state agency designated by the Governor of each state. Recipients include the aged, blind and disabled, and dependent children of eligible families.

Eligibility

Eligibility requirements for Medicaid vary from state to state. However, three standard groups are eligible for Medicaid coverage:

1. The Categorically Needy - Those persons receiving or eligible to receive federally subsidized public assistance payments. The ratio of categorically needy Medicaid beneficiaries to the total population of a state is related to the upper limits a state places on its cash public assistance payments. The higher the payment, called the "state standard," the more persons whose income will fall below it.

Those covered under the categorically needy group include:

a. All individuals receiving Aid to Families with Dependent Children (AFDC) payments.

b. Individuals who have become ineligible for AFDC because of increased earnings will be eligible for 4 months as of the month they originally became eligible for cash assistance to ease the transition into regular employment.

c. Coverage must also be extended to a large share of those who are eligible for Supplemental Security Income (SSI). SSI will be discussed in greater detail later. However, it should be noted that a state may cover all SSI recipients under the categorically needy group.[2]

2. The Medically Needy - The medically needy are persons who have incomes which are high enough that they would normally be ineligible for state public assistance payments, but are not high enough to meet their basic food, shelter and clothing needs if they were also to pay their medical bills.

3. The Medically Needy Children - In order to qualify under federal regulations financial eligibility, a dependent child must be without a father or mother in the home as a result of divorce, death of a parent, or separation of the parents. This section extends Medicaid coverage to children living in intact households where the family's income is below the state's AFDC coverage. It also allows for coverage of reasonable subclasses of individuals under 21. Such "subclasses" include children in foster homes, private institutions, or in subsidized adoptions when a public agency is assuming financial responsibility...[3]

In august, 1982, Congress approved a provision that would allow children under the age of 18 to receive Medicaid benefits for care at home under the following conditions: (1) the child requires the level of care provided in an institution; (2) the same care the child would receive in an institution can be received outside the institution; (3) the cost of care at home is not more expensive than in an institution; and (4) a family's income meets eligibility criteria as outlined under SSI requirements.

Under Medicaid provisions, the two most important services for the mentally retarded are the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

These services are required and must be administered to the client.

The services a mentally retarded client can receive under EPSDT include:[4]

1. assessment of the child's physical and mental health and his growth and development.

2. check-ups and appropriate referrals to physicians and clinics for treatment in the following areas:

vision
hearing
dental problems
growth and development
nutrition
immunizatin
heart disease

tuberculosis
kidney disease
veneral disease
anemia and sickle cell
parasites
lead poisoning
drug abuse

3. eyeglasses and hearing aids will be made available.

4. transportation will be provided if a child cannot take advantage of the program without it.

Intermediate Care Facilities (ICF/MR)

Under ICF/MR provisions, strict regulations must be adhered to in order for the client to receive maximum benefits from the program. A facility must show that the client is receiving "active treatment" as defined by federal regulations before payment can be received under Title XIX. Active treatment includes:[5]

1. Regular participation in accordance with an individual plan of care in professionally developed and supervised activities and therapies;

2. An individual "plan of care" which is a written plan setting forth measurable goals or behaviorally stated objectives and which prescribes an integrated program of individually designed activities, experiences or therapies necessary to achieve such goals or objectives. The overall objective of the plan is to attain or maintain the optimal physical, intellectual, social, or vocational functioning of which the individual is presently or potentially capable;

3. An interdisciplinary professional evaluation consisting of complete medical, social, and psychological diagnosis and evaluation, and an evaluation of the individual's needs for institutional care, prior to but not to exceed three months before admission to the institution...The evaluation is to be conducted by a physician, a social worker and other professionals;

4. Re-evaluation - medically, socially, and psychologically - at least annually by the staff involved in carrying out the resident's individual plan of care, including review of the individual's progress toward meeting the plan objectives, the appropriateness of the individual plan of care, assessment of continuing need for institutional care, and consideration of alternative methods of care; and

5. An individual post-institutinalization plan...developed prior to discharge by a qualified mental retardation professional and other appropriate services, protective supervision and other follow-up services in the resident's new environment.

The concept of intermediate care facilities (ICF/MR) got its start in the early 1970's. With the enactment of Public Law 92-223 in December, 1971, the authority for intermediate care facilities was transfered from Title XI to Title XIX. Practitioners recognized that many clients in state and private institutions did not require 24-hour intensive nursing care. According to Litvin and Browning (1977), the move to deinstitutionalize had many positive effects as people who were released were able to find gainful employment and become self-supporting. However, the negative effects far outweighed the positive in that funds were scarce and unavailable in most instances for room and board services.

ICF/MR services are either employed through contractural arrangements or through direct provisions. They include:

1. Dental services or those services which provide an evaluation, diagnosis, treatment and annual review of the resident's dental health. Care must be provided for dental emergencies under supervision of a dentist.

2. Physical and occupational therapy services which must be under the supervision of a physician or a physical or occupational therapist who meets state licensing standards.

3. Psychological services which include individual treatment and consultation if necessary. Such services must be rendered by a person with at least a masters degree in psychology.

4. Social services must be made available to all residents as appropriate; participation including evaluation and counseling with

referral to, and use of, other community resources as appropriate; participation in periodic reviews; and planning for community placement, discharge and follow-up services.

5. Speech pathology and audiology services are for those who need them. They must be provided under the direction of a physician or a speech pathologist or audiologist.

6. Organized recreational activities are provided for residents consistent with their needs and capabilities. Adequate recreational areas and equipment must be provided.

7. Physician's services: a complete annual physical examination is to be performed, and there must be formal arrangements to provide for medical emergencies on a 24-hour 7-day-a-week basis.

Intermediate Care Facilities (under Public Law 92-223) are defined as, institutions which:[6]

1. are licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment a hospital or skilled nursing home is designed to provide, but who, because of their mental or physical conditions require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

2. meet such standards prescribed...as...appropriate for the proper provision of such care; and

3. meet such standards of safety and sanitation as are established under regulation...in addition to those applicable to nursing homes under State law.

ICF services are included in public institutions for the mentally retarded or persons with related conditions if:

1. the primary purpose of such institutions is to provide health or rehabilitative services for mentally retarded individuals and which meet such standards as may be prescribed...;

2. the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

3. the state or political subdivision responsible for the operation of such institutions has agreed that the non-federal expenditures with respect to patients in such institutions will not be reduced because of payments made under this title.

30

Medical practitioners began to realize that there were persons with handicaps in 24-hour, intensive nursing homes that did not require constant care. However, the resident did require care and services that went beyond simple room and board, particularly in the areas of social interaction, therapeutic and developmental services and recreation. Thus, the ICF concept originated as a possible level of care existing between room and board and intensive nursing facilities.

Conflict arose in the ICF's orientation between a medical model and the developmental model. This conflict was particularly felt in the area of funding since ICF's are a provision of Medicaid:[7]

1. Early regulations required that the director of an ICF/MR be licensed as a nursing home administrator.
2. Services of the ICF/MR had to include the entire spectrum of skilled nursing services, generally not needed by all the potential residents.
3. In most states, the agency with the authority to license ICF/MR's is the Health Department which may use the same criteria for licensing ICF/MR's as for skilled nursing facilities and general ICF's.

A recent trend by service providers and advocates has been to stress the developmental model of placing individuals in ICF's with the intention of training the people in independent living skills. There are currently three levels of Intermediate Care Facilities:[8]

Level I: Small residential homes of 15 beds or less designed to provide long term or transitional living opportunities for persons who may be moderately or mildly developmentally disabled.

Level V: Programs offered in nursing home-type environments, (which) provide developmental services to persons who are moderately to severely handicapped and who require greater degrees of programming and supervision than the Level I residents.

Level IV. Programs also typically housed in nursing home-type environments (which) serve persons who are severely or profoundly handicapped with restrictive medical or behavioral problems.

The ICF/MR application and certification process is rather lengthy and involved. For the benefit of the service provider who wishes to utilize ICF services, Bright (1981) lists a series of steps that service providers in the state of Texas must follow to gain access to ICF/MR programs. Service providers should contact those agencies and departments that are similar in function to those mentioned under the Texas plan:[9]

1. Potential ICF/MR service providers should determine generally the level of ICF/MR services they intend to provide (i.e. Levels I, V, or VI) or other general DD groups they wish to serve (i.e. epilepsy, autism, cerebral palsy, etc.).

2. Providers should contact personnel in the Professional Services Division or the Quality Standards Division, Bureau of Long Term Care of the Texas Department of Health. From these offices, providers can receive copies of the ICF/MR regulations and other information and materials to the TDH certification process.

3. Providers should contact the Architectural Division, MR Section, of the Texas Department of Health. This division is responsible for certifying the physical facility in which the proposed ICF/MR program is to be housed. ICF/MR facilities must meet provisions of the Life Safety Code and other required standards. Building plans must be submitted to the Architectural Division for review. Personnel of the Architectural Division may then conduct a site visit to the facility to advise providers as to their level of compliance with application standards and codes. Ultimately, the Architectural Division is responsible for certifying that the facility has met all necessary building requirements.

4. Providers should establish and justify with appropriate documentation that a need for the services that they propose to provide actually exists.

5. Educational and vocational services are non-reimbursable under ICF/MR programs. Therefore, providers must engage in appropriate preplanning activities which impact Independent School Districts and the Texas Rehabilitation Commission or other local vocational service providers to meet the needs of clients who will require such services.

6. Completion of a planning checklist by TDMHMR officials is necessary based upon documentation submitted by the provider.

7. Providers should contact personnel at their regional Health Systems Agency (HSA) office. HSA reviews of proposed ICF/MR projects are a necessary element in the Certification of Need process conducted by the Texas Health Facilities Commission (THFC). The degree of HSA involvement in this process and the type of planning review conducted

differs considerably from one HSA regional office to another. Providers should inquire as to all applicable HSA review procedures and comply in full with such requirements.

8. The Certificate of Need process involves documentation that verifies substantial need for ICF services, that the program is cost-effective, that providers can competently develop and administer the program, and that the program's services are not the same as those already existing in the same area.

9. Once the provider has received a Certificate of Need, he should apply to the Texas Department of Human Resources (TDHE) for a Contract for participation in the ICF/MR program. The application should be made to the Certificate Services Section. All relevant application material can be obtained directly from that office.

10. The application to TDHR for a Contract for Participation in the ICF/MR program triggers a notification from TDHR to the Certification Services office of the Quality Standards Division of the Texas Department of Health regarding the intent of the provider to be certified for participation in the ICF/MR program.

11. The provider should notify the Architectural Division to schedule a date on which their personnel will conduct a site visit to certify the physical facility in which the ICF/MR program is to be housed.

12. Concurrently with Step 11, providers should contact the MR Program Office of the Quality Standards Division of the Texas Department of Health to schedule a date for the ICF/MR certification survey of the facility.

13. Providers will need to admit at least one resident to the facility prior to the on-site survey by the MR Survey Team.

14. On the scheduled dates, the MR survey team will conduct an on-site visit to evaluate the program on the basis of ICF/MR standards and regulations. Upon completion of the survey, the Survey Team will recommend certification of the providers program to the Texas Department of Human Resources, Certification Services Section. The Survey Team's positive recommendation on certification is generally tantamount to approval by DHR.

15. Concurrently with final phases of the facility/program certification process, individual residents of the proposed ICF/MR facility must be certified and "typed" for participation in the program prior to admission. Specifically, a "Level of Care" determination must be made by the TDH regional MR Program Teams.

Certificate of Need

A few states require a document known as a Certificate of Need if they use ICF/MR Title XIX Medicaid funds. Texas is one such state that must comply in order for the state's health facilities to avoid duplication of services and provide care in a more cost effective manner. A Certificate of Need document stipulates that there is a substantial need for the proposed service, that the program is cost effective, and that the services provided are not duplicating existing services in the same area.

In Texas, regional Health Systems Agencies and the Texas Health Facilities Commission are responsible for reviewing applications for Certificate of Need and for seeing that facilities comply with the regulations governing such a document. All facilities that are medically oriented, including ICF/MR facilities of 15 beds or less, are subject to the requirements of the Certificate of Need as they are funded through the Title XIX Medicaid programs.

Because the Certificate of Need application process is rather lengthy, the service provider should contact the state agency responsible for carrying out the application process at least 6 to 9 months prior to the proposed date for starting a program. The type of information usually contained in a Certificate of Need document includes the following:

1. Certificate of Need requirements
2. Criteria for use in Certificate of Need reviews:

    -medical service area;
    -health-care requirements;
    -relationship to existing or approved services and facilities;
    -less costly or more effective alternatives;
    -personnel and operation;
    -economic feasibility;
    -special requirements;
    -relationship of the proposed plans to existing plans;
    -criteria for safety factors and accreditation, or licensing, or certification standards.

3. Preapplication instructions
4. Application packet and instructions
5. Certificate of Need review and hearing process

An applicant can file for a Motion to Amend an accepted Certificate of Need on bed capacity or licensed beds; categories of beds; the number of beds in a category; project cost; movable or fixed equipment; services; medical service area; the gross area to be constructed, renovated, purchased, leased, or donated; the location of a project; and legal ownership.

Upon dating and acceptance of a Certificate of Need application by the appropriate agency, a review is conducted and a hearing is scheduled on the application. Criteria form the basis of the review and the burden of proof is on the applicant to present information in the application and evidence of facts at the hearing which address each relevant criterion satisfactorily, before a Certificate of Need meets approval.

Supplemental Security Income

When the Social Security Act of 1935 was enacted, one of its purposes was to provide for retired persons a pension program that was insured and administered by the government. Under this program, a person who had worked for a certain period of time in covered employment could retire and receive a monthly benefit check from the Federal Government.[10]

Title II of the Act became the authorization which established services for retired citizens. A problem arose in that Title II was strongly tied to work/wage requirements and many people, who were not eligible under those requirements, could not receive the needed assistance. As a result, public assistance and welfare programs were established under the Act to provide a "residual system" for adequate income to needy individuals who were not protected by the social insurance system or whose benefits under that system were insufficient to meet their needs. SupplementalSecurity Income (SSI) is a direct outgrowth of these early support programs.

Authorized under Title XVI of the program, SSI became law on January 1, 1974. Unlike Medicaid which is based on the state-federal partnership, SSI is federally controlled due to problems that arose with the implementation of early public assistance programs across the states. For example, it was found that in some states the aged, blind and disabled were only receiving between 9 and 10% of the total state budget for payments in aid. Varying eligibility requirements across the states caused even more discontent with these early programs. As a result, states were given a time limit between 1972 and 1974 to make the switch from state control to federal control of the SSI program.

Depending on the state which implements the program, SSI provides eligible recipients with minimum cash payments along with additional state supplements (i.e., Medicaid). As of July 1, 1982, SSI payments constitute $284.30 per month for single recipients. However, SSI benefits are reduced to a maximum of $25.00 per month for individuals entering an institution or residence which is receiving 50% or more of the resident's care from Medicaid.[11]

For those individuals residing in alternative living environments that did not meet intermediate care facility requirements, service costs (other than basic room, board and laundry services) were deducted from the individual's SSI monthly check. According to Litvin, this served a two-fold purpose:[12]

> 1. It let the SSI recipients know that they would be penalized if they paid for services in board and room homes which would better be rendered in an adequately staffed intermediate care facility.
>
> 2. It...placed the burden indirectly upon state and local agencies not to pay for high level services in room and board facilities.

Because it was less expensive to place individuals in ICF's, group home admissions were seriously hindered and many clients were inappropriately placed in ICF's. Another, closely related problem arose for group home residents in that support given to homes by the state was considered "unearned income" and in many cases the residents were ineligible for financial assistance under SSI requirements. An amendment known as the "Church Amendment" (P.L. 93-484) exempted certain types of financial support to include funds provided by private non-profit sources; funds used to pay for the cost of room and board only; and funds used to support private, non-profit, and non-medical (i.e., not an ICF) group homes.

Under the Ford administration, three significant amendments to the SSI program established legislation that extended benefits to recipients in group homes and authorized a new assistance program for SSI eligible children.

The first amendment, known as the Key's Group Home Amendment, basically redefined a public institution by excluding poblicly operated community residences serving 16 or fewer persons. The purpose was to assure SSI recipients that the supplemental income they received from the local and state government would not be counted as "unearned income." Another basic element of the amendment established standards for care in non-medical facilities (i.e., group homes) which the states are to enforce and maintain. The Key's Group Home Amendment significantly opened the door for the development of group homes for the mentally retarded.

The second significant amendment, known as the Mikva Child Referral Amendment, established a provision for the referral and payment of needed services to eligible children. The third and final amendment was directed toward the eligibility criteria for SSI children. Accordingly, a retarded child under 18 is considered disabled if it is shown that:

1. the child's IQ is 59 or less;

2. the child's IQ is 60 through 69 and the child has marked dependence, in relation to age, upon others for meeting basic personal needs, and a physical or other mental impairment that restricts function and development; or

3. achievement of developmental milestones is no greater than would generally be expected of a child half the applicant's age.

Eligibility Requirements

Requirements for SSI are divided into four areas: Age and Disability, Income Limitations, Resource or Asset Limitations, and Other Facotrs. Litvin and Wilson break these categories down into separate eligibility requirements.[13]

Age and Disability

1. A person's age must be 65 years of age or older if age is used by the applicant to meet eligibility.

2. To qualify on the basis of disability, the applicant must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. A child under 18 is eligible if his impairment disables him for a year or more were he an adult.

Income Limitations

Though countable income is used to reduce the amount of the monthly SSI benefit, the program provides for disregarding or not counting several types of income in computing the amount of an SSI benefit:

1. twenty dollars of unearned income is disregarded plus one-half of what is left over above $85.00 (i.e., One dollar is disregarded for every $2 earned over the $85.00 amount),

3. regular cash payments made by a state or local political subdivision (based upon need),

4. income necessary for a blind or disabled individual to fulfill a plan for support,

5. a blind individual's work expenses,

6. the earnings of a child attending school,

7. casual earnings from odd jobs, babysitting, etc. (if it totals no more than $30 per quarter),

8. tax refunds on real property or food puschases,

9. scholarships or fellowships to the extent that they cover the cost of tuition and fees,

10. the value of home-grown produce consumed by the individual recipient and his family,

11. one-third of child support payments received by an eligible child from a parent who is not living in the home; and

12. foster care payments for a child who has been placed in an SSI recipient's household by a foster care agency.

Resource of Assets

1. An eligible individual is allowed up to $1,500 in value of countable resource. Eligible couples are allowed $2,500.

Other Eligibility Factors

1. The recipient must be a resident of the United States. If he leaves the country for 30 days or more, he must reside in the United States for 30 consecutive days to re-establish his eligibility.

2. A person must file for any other benefits he may be eligible for in order to qualify for SSI.

3. A beneficiary who is blind or disabled is required by Public Law 92-603 to accept the services of a state vocational rehabilitation agency as they are made available.

4. A person is not eligible for SSI during the time he is a resident of a public institution. However, an institutionalized individual is eligible if the public institution is receiving Title XIX (Medicaid) payments in his behalf and the amount of those payments represent more than 50% of the cost or charges (whichever is lower) in treating him. For persons in private nursing homes or Intermediate Care Facilities, the private rate is lowered to $25 per month.

Title XX

In 1975, President Gerald Ford signed into law what is considered to be one of the last reorganizations of federal social service legislation for many years - Title XX established a new assistance program for the developmentally disabled and low to moderate income families. The program can be found under the public assistance programs of the Social Security Act and is based on a state and local/federal matching funds formula. According to Litvin (1977), the impact that Title XX has at the state level is that it theoretically:[14]

-provides for an expansion of possible services offered and numbers of individuals to be served;

-places full accountability for planning and administering the program at the state level;

-requires the development of new planning, financial management, and reporting practices at the state level; and

-provides for accountability to the citizens of the states through a public planning process.

The goals of Title XX are strongly based on reducing dependency and fostering economic self-support and self-sufficiency. Litvin lists these five broad goals as:

1. achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
2. achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
3. preventing or remedying neglect, abuse, or exploitation of children or adults unable to protect their own interests;
4. preventing or reducing inappropriate institutional care by providing community based care, home-based care, or other forms of less intensive care; and
5. securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

The program provides funding for a wide array of services that are directly linked to one or more of the goals. Examples of these services include: housing, transportation, employment, legal services, child care, protective services for children and adults, service for children and adults in foster care, home maintenance and management services, adult day care services, training and related services, information and referral, counseling, health support services, etc. Of particular importance to service providers who wish to set-up residential facilities and programs is goal number four, which provides funding for community-based residential alternatives and home-based serivces as listed in a draft of a training module by Litvin (1977) on Title XX and Developmental Disabilities, home-based services include:

1. Homemaker Services - General household management activities such as meal preparation, child care, and routine household care. Most often, homemaker services are provided on a temporary basis, and when appropriate, they include an element of teaching the client how to do it for him/herself.

2. Chore Services - Most often described as home-maintenance activities such as repairs, yard work, shopping, house cleaning.

3. Home health Aide Services - Medical home care activities provided by nursing aids.

4. Home Management Services - Described as formal or informal instruction and training in child care, home maintenance, meal preparation, budget management, and consumer education.

Also, services can be clustered together to allow for funding for special service needs for designated target groups: children, aged, mentally retarded, blind, emotionally disturbed, physically handicapped, alcoholics, and drug addicts.

In applying for services, there are particular rules that must be followed, such as:

1. Each service offered under a service plan must be described as a separate identifiable service.

2. The method of delivery and the service's relationship to one or more program goals and objectives must be specified.

3. Each service must be identified with respect to each of the categories of eligible individuals to whom the service is to be provided and to each of the geographic areas described in the service plan.

4. Clustered Service. Every service must be defined and described so that it is clear exactly what activities are included in the provision of the service. Federal financial participation (FFP) is available for expenditures for clustered services which are defined in terms of groups of activities only if they are broken down into particular, separately identifiable services. For example, "services for the emotionally disturbed child" is too broad and must be broken down to include a description of all the activities involved, such as counseling, room and board, etc.

One other very important area of Title XX is the eligibility requirements applied to medical/remedial or room/board service expenditures. FFP is available for these services if it can be shown that they are an integral but subordinate part of a larger social service. In other words, for each social service the medical/remedial or room/board component must be an essential part of the service.

To understand this criterion, the following rules can be applied to determine if medical/remedial or room/board components are integral to the operation of a service.

Medical/remedial components apply if:

1. they are necessary to achieve the objective of that service and not merely to correct a medical condition; and

2. the specific medical and remedial care are described and included in the service of which they are an integral but subordinate part.

Room/board components apply if:

1. it is necessary to achieve the objective of that service and not merely to provide food and shelter; and

2. room and board are included in the state's service plan along with a description of the services of which it is an integral but subordinate part.

Eligibility

Title XX is one of the few federal programs that does not necessarily use income maintenance as its sole determination of eligibility. There are three categories of eligibility criteria including: low-income, non-income (based on need), and income maintenance.

Low Income. Individuals or families are eligible for Title XX if their income is 115% below the state's median income level (adjusted for family size). A fee for services is charged for gross monthly incomes above 80% of the state's median income or 100% of the national median income (if lower). Also, income limitations are higher for the developmentally disabled than for other income eligible individuals.

Non-Income (need). Those individuals who require information and referral services, child and adult protection services, and family planning services are eligible under the need alone category of Title XX.

Income Maintenance. Those individuals who receive SSI benefits, Title XIX (Medicaid) benefits, or Title IV (Aid to Families of Dependent Children) are eligible to receive Title XX benefits. Here a "fifty percent rule" applies in that a minimum of one-half of the federal funds (37.5 percent of the total matchable program) must be spent on the recipients.[16]

Federal matching of funds is not available for services rendered to individuals in nursing homes, intermediate care facilities, prisons, or foster care homes if the services provided are directly from the facility in which the individual lives. Other restrictions on federal funds include the following:[17]

-Matching is not available for expenditures for the provision of services to individuals not receiving AFDC or SSI who are members of families with an income in excess of 115% of the median income of a family of four in the state (adjusted to take account of family size).

-Matching is not available for expenditures for most services unless certain requirements concerning fees for those services are met. In the case of services provided to individuals receiving AFDC or SSI or who are members of families with incomes below the median income of a

44

family of four in the United States, or 80% of the median income of a family of four in the state (in question), the secretary must prescribe requirements concerning the imposition of fees.

-Matching is not available for medical services except in certain circumstances; for the purchase, construction, or major modification of buildings, facilities, or equipment, or for the provision of room and board except in certain limited circumstances.

-Matching is not available for expenditures in the form of goods or services provided in kind by a private entity, and is available for expenditures of donated private funds only if the funds are transferred to the state and under its control, are donated without restrictions as to use with certain limited exceptions, and do not revert to the donor's use unless the donor was a non-profit organization.

-Matching is not available for expenditures of child care unless the care meets certain standards.

-Matching is not available for expenditures for the general educational program of the state.

-Matching is not available for expenditures for the provision of cash for income maintenance purposes.

Participation in Title XX funding depends on the development of a state administrative plan and a Comprehensive Annual Services Program (CASP). The state plan must cover two areas: designation of the state agency authorized to administer requirements which include such duties as conducting fair hearings for persons who have been denied service requests, establishing standards for services provided to individuals in institutions or foster homes (for those states that provide such services), observing proper confidentiality, developing personnel and merit systems standards, etc.

The Comprehensive Annual Services Program Plan (CASP) is prepared and finalized by the agency authorized by the state administrative plan. The plan must contain the following information:[18]

-program objectives;

-services to be provided, their definition and relationship to objectives and goals;

-categories of individuals to be served (including income categories);

- geographic areas for service provision and nature and amount of services for each area;

- a description of Title XX planning, evaluation, and reporting activities;

- sources of the program funding;

- a description of organizational structure, including use of public and private agencies and volunteers;

- a description of Title XX coordination with and utilization of related human service programs (i.e. Medicaid, SSI);

- estimated expenditures of services, categories served, geographic areas and a comparison of estimated non-federal expenditures for the planning year and the preceding program year; and

- a description of steps taken to assure that needs of all residents and geographic areas of the state were considered in plan development.

The most important component of the planning cycle is the needs assessment. If a substantial need for services is demonstrated, Title XX funding is often established. The needs assessment must include data sources, those public or private organizations consulted, and information on how the results of the needs assessment were used to develop the service plan.

Title XX funds used in conjunction with those of other human service programs (particularly SSI) have opened the doors to the development of alternative living environments for the developmentally disabled. In many instances, Title XX is used to pay for supplemental/supportive services.

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[14] Litvin, 1977, pp. 62-63.

[15] Litvin, M. Title XX and the developmentally disabled. Federal Programs Information and Assistance Project. Washington, D.C.: GPO (draft), 1977, pp. 13-17.

[16] Litvin, 1977, p. 61

[17] Litvin (draft), 1977, pp. 37-38.

[18] Litvin, 1977, pp. 72-73.

Chapter III

Planning and Locating Community-Based Living Facilities

Assessing the Local Housing Market

Locating an existing facility for an alternative residential program is often a tedious and frustrating job. The numerous safety regulations and guidelines that a facility must meet often limit the selection. Also, service providers are faced with community pressures including hostile, neighborhood coalitions who do not wish to see a residential program for the mentally retarded established in their area. However, due to increased interest of advocacy groups and acts of legislation promoting the rights of the handicapped to live in the least restrictive environment, community integration is becoming more prevalent.

When looking for available and suitable facilities for residential programs for the mentally retarded, service providers are often faced with a "search and find" process. McGuire (1977) suggests the following factors when searching for available housing:[1]

1. Identify the location of a variety of single- and multi-family houses or apartments for purchase or for rent that are barrier-free and which may be used by physically handicapped persons. This inventory for handy reference and use will lighten the search burden for those who have limited mobility and difficulty in getting around.

2. Search out and inventory those dwellings that may be used by physically handicapped persons if the architectural barriers can be readily removed. Determine the extent and cost for renovation; check whether the owner will defray this cost and, if not, what other financial plan is possible. In areas with high vacancy rates, it has been found that owners will undertake this renovation at their own expense. In public housing developments, the local authority may be willing to use its modernization funds to defray this expense. Also, investigate the possibility of obtaining housing renovation funds from the state rehabilitation agency.

3. Locate available properties in the community, under either public or private ownership, that may be leased or rented to individuals or to

a group acting in behalf of certain individuals, e.g., severely handicapped or mentally retarded persons or combinations of the two groups. Be sure that these facilities are within the paying ability of potential occupants; are reasonably well located; and are adaptable for the intended use.

An analysis or assessment of the local housing market in a given area works hand-in-hand with a determination of the extent of need and demand for alternative residential facilities. In looking at need factors, the service provider should be aware of the "numbers" involved:[2]

-numbers of overcrowding in substandard housing in the area under consideration.

-numbers of persons in poorly located or otherwise inappropriate shelter.

-numbers of persons who are institutionalized unnecessarily.

-numbers who are housebound.

-numbers who pay too much for shelter in relation to their income.

From these "numbers," the service provider can determine a demand factor: a demand for housing that satisfies each need factor. According to McGuire, an estimate of need can be established by identifying the following:

-Total number and location of handicapped persons in the area to be served;

-Category of disability and functional capacity of each;

-Age, sex, and marital status;

-Income and its sources, e.g., Social Security, SSI, etc.;

-Current living situation, i.e., in family homes, shared dwellings, substandard or inappropriate housing, etc.; and

-Educational and occupational status.

McGuire further states that an elaborate scientific study of a specific market area is often not necessary for establishing a demand for residential facilities, particularly if there are only a small number of units under consideration. However, if it is felt that an elaborate study should be made as mandated by municipal officials or funding sources, then a total number of handicapped individuals and their location in a catchment area can be found from the following sources:[3]

- Local chapters of national organizations interested in one or another type of handicaps, such as the National Easter Seals Society, United Cerebral Palsy Association, Goodwill Industries, the Association for Retarded Citizens, etc:
- Welfare or other agencies providing income for the handicapped, including the Social Security Administration office;
- Vocational rehabilitation agencies that provide training and other services or maintenance costs;
- High schools, colleges, and universities, whether or not they specifically accommodate the handicapped;
- The local array of medical institutions, nursing homes, etc., and most particularly, rehabilitation hospitals;
- Training and employment centers and workshops, many of which may have lists identifying handicapped persons who are homebound;
- Industries and businesses known to employ handicapped persons, as well as the local employment agencies;
- Mental health and mental retardation centers, physical therapy centers;
- County medical society;
- City planning department and other agencies or groups that conduct population surveys; and
- Local insurance companies and worker's compensation offices.

If the service provider finds that a comparison to national need will help dramatize the urgency of local need, the provider can tap such sources as the U.S. Census Bureau, the Social Security Administration, the Veterans Administration, the National Center for Health Services (to indicate disability classifications), the Department of Health and Human Services, President's Committee on Mental Retardation, and the President's Committee on Employment of the Handicapped.

Available Funds for Residential Facilities

The 1930's ushered in a wave of housing programs that greatly influenced metropolitan growth and social and economic opportunity throughout the United

States. Many of these early programs still have an influence on housing credit markets and the housing industry as a whole. Programs such as the Federal Housing Administration (FHA), the Federal Savings and Loan Insurance Corporation and the Federal National Mortgage Association (FHMA) helped low and moderate income families finance the purchase of new or existing homes by offering mortgage insurance, low down payments, and long term amortized mortgage loans. The FHA was instrumental in standardizing the provisions within mortgage policies creating a national credit market.

Inflation has caused a major shift in the direction the housing industry has taken in recent years. Since 1970, housing prices have skyrocketed along with labor and construction costs. The median sales price for a home today is estimated at over $78,000. Current interest rates on the purchase of an FHA insured loan are 15%, plus 1/2% for mortgage insurance. Though this figure fluctuates from year to year, 15 1/2% is comparatively low considering that interest rates in April, 1980, were as high as 18%.

Government subsidy programs emerged in direct response to the reduction of private capital costs for the production of new or remodeled housing units. A majority of the subsidy programs were targeted toward those individuals or families, the elderly, and the handicapped. Because of our current state of economic pressure, drastic budget cuts are being made at the federal level in an attempt to reduce the high interest rates and stimulate growth in the private housing sector.

Housing Assistance Programs for the Handicapped

The Department of Housing and Urban Develoment (HUD) provides the most comprehensive housing assistance for the handicapped. These programs can be used by advocacy groups or through direct sponsorship to ensure residential alternatives for those in need of such assistance. Among the most prevalent of the HUD assistance programs are Section 8 and Section 202. Low-Income Public Housing, another HUD program, is a moderate income assistance program that can be used for independent living.

Housing loans can be obtained through another, but more restricted source, the Farmers' Home Administration (FmHA). Loans under FmHA programs provide housing in rural areas. The most prevalent of these loans is Section 515 which can be used specifically for congregate housing and group homes. Sections 502 and 504 are more limited in scope and only available in specified areas.

Section 8: Housing Assistance Payment Program

Under Section 8, rent subsidy is used for operating expenses and mortgage payments. Payments are made directly to the owners of rental units. Tenants are required to pay up to 30% of their adjusted income as HUD picks up the remainder of the approved rental amount. For example, the handicapped person who earns an annual income of $4,000, could rent a HUD approved, one-bedroom elevator apartment for $153.00. Eligibility for Section 8 assistance is dropped when the total family contribution equals the total housing expense of the occupied unit.

Fair Market Rents (FMR's) are currently applied to contract rents in determining rents and utilities comparable to a given market area. FMR's are determined by unit size, unit type, and occupant type (i.e., the elderly, handicapped). Generally, contract rents cannot exceed Fair Market Rents unless the costs for rehabilitation are less than 25% of the estimated property value. FMR's are published annually in the Federal Register.

There is a move underway to abolish the FMR formula. Should this happen, HUD plans to substitute housing vouchers as the new financial mechanism. Assistance will be based on the difference between each market rent payment (40% of the distribution of rents in a given area) and a fixed percentage of family income (30% for all new tenants). Acording to HUD, the vouchers will give tenants more power in determining how much of their income will be spent on housing, more responsibility in rent payment, and more freedom in choosing suitable housing for their individual needs.

Advantages of Section 8

1. Section 8 is flexible in that it covers existing housing, newly constructed or substantially rehabilitated housing, or combines with state housing agency programs. There are currently six types of Section 8 rental assistance programs:[4]

New Construction - supports the operation of a project once it has been built;

Substantial Rehabilitation - subsidizes renovation;

Existing Housing - provides subsidies to eligible tenants already occupying privately owned housing, who can retain their eligibility and move elsewhere;

State Agency - provides funds for state-operated housing where any other program is not available;

Farmers' Home Administration - funds rural housing usually through the New Construction program, and;

Loan Management Set-Aside - makes additional payments for operational costs of housing units rather than payments to tenants.

2. An individual's annual income need not exceed 80% of the medium income for the area to be eligible under Section 8 assistance.

3. Section 8 guarantees the availability of program operational funds as a source of income for mortgage payments up to 20 years. If additional state financing is used, the time period is extended to 40 years.

Section 202: Housing for the Handicapped and Elderly

Under Section 202, nonprofit organizations are provided direct loans which cover 100% of the costs of constructing or rehabilitating rental housing for the handicapped or elderly. Typical organizations who have applied in the past for Section 202 assistance include religious and fraternal groups, civic clubs, social service organizations, unions, senior citizen groups, and associations for the handicapped. Before loans are guaranteed, the sponsors must submit a plan that details those services and facilities available to the tenants (i.e., health, continuing education, welfare, information services, recreation, homemaking, counseling, referral services, transportation).

The major difference between Section 8 and Section 202 is that Section 202 funds can only be used for construction purposes. Section 8 provides the rental assistance which subsidized a tenant's rent. Section 202 not only provides the largest source of support for HUD projects, but also delineates which programs assist the physically handicapped and which assist the developmentally disabled. Current regulations require all Section 202 projects to provide provisions for the physically disabled rather than just for the people with developmental disabilities.

Advantages of Section 202

1. Section 202 guarantees direct, 40-year federal mortgage loans which cover up to 100% of the total costs for constructing or rehabilitating housing projects for the handicapped, developmentally disabled, or elderly. Section 202 also applies to congregate housing.

2. Section 202 can be used in conjunction with other housing assistance programs to provide the maximum amount of aid in establishing residential alternatives for the handicapped, developmentally disabled, or elderly.

3. Section 202 requires a comprehensive plan that details services and facilities available to tenants.

4. Section 202 enhances opportunities for normal community living by requiring sponsors to locate group homes or apartment complexes in residential neighborhoods and not close to other specialized facilities such as workshops or half-way houses. Also, group homes may not serve more than 12 persons, nor

may there be more than one facility per site.

Eligibility for Section 8 and Section 202

HUD Section 8 eligibility requirements include one of the following:[5]

- a family;
- individuals at least 62 years of age;
- disabled or handicapped;
- displaced individuals;

HUD Section 202 eligibility requirements include one of the following:[6]

- two or more elderly or handicapped persons living together;
- one or more elderly or handicapped persons living with another person determined to be essential to their care;
- a surviving member or members of any eligible family, if the family were living in the housing unit at the time of the deceased family member's death;
- a single person who is at least 62 years of age;
- low to moderate income handicapped single adults under the age of 62; or
- the chronically mentally ill.

For the handicapped to meed HUD eligibility requirements as a family, the following conditions apply:[7]

1. His or her impairment is expected to be of a long-continued and indefinite duration.
2. The impairment substantially impedes his or her ability to live independently.
3. His or her impairment is of such a nature that this ability could be improved by more suitable housing conditions.

Furthermore, as published in the Federal Register (1978), a handicapped person is designated as:[8]

> ...handicapped if he or she is developmentally disabled, i.e., if he or she has a disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition found...to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which disability originates before such an individual attains age eighteen, which constitutes a substantial handicap to such an individual.

How to Apply for Section 8 and Section 202

As of March 1978, application requirements for both Section 8 and Section 202 have been consolidated. Therefore, rental assistance applied for under Section 202 is considered applicable to receive Section 8 assistance as well. Under Section 202, HUD has opened competitive applications for group homes sponsoring up to 50 residents as well as independent living centers sponsoring no more than 20 residents. Applicants must show evidence of financial ability and invest 1/2 of 1% of a Section 202 loan or a minimum of $10,000. It is extremely important that information contained in each application is accurate and technically correct.

Area HUD offices publish an *Announcement of Fund Availability* and *Invitations for Applications for Section 202* in local newspapers servicing an allocation area. Publication occurs once a week for two weeks in March and/or April. The local minority media, organizations involved in housing and community development, and social interest groups are also notified for application procedures. June 15 has been officially designated as the deadline for filing applications for housing assistance. Area HUD offices also conduct workshops two to three months in advance of this deadline. At the workshops, all questions are answered as program information is disseminated and regulations and instructions governing the programs are discussed in detail. Here, interested parties may pick up applications to meet the June 15 deadline.

Future Trends in Funding

According to a 1982 federal report, HUD has identified several serious defects in their programs including:[9]

1. Long-term subsidy commitments which result in uncontrollable budget outlays;
2. Caps on tenant rent contributions resulting in unanticipated cost increases borne solely by the federal government;
3. Subsidies tied to specific rental units;

4. Per unit subsidy costs which are too high.

A major change in funding will occur with a proposed termination of all Section 8 New Construction projects. Because new units currently cost $4,000 per unit to construct, HUD plans to cut back 145,000 of the 400,000 units currently under construction and eventually shift New Construction funds to funds used for the modernization of existing units. Recent legislation has raised the limit for group homes to serve up to 15 persons per site as opposed to the original limit of 12.

Low Income Public Housing

Under Low Income Public Housing, the department of Housing and Urban Development provides technical assistance and loans to public housing authorities (PHA's). With such loans, the PHA's plan, develop or purchase, operate, and provide services for rental housing for low income families. Five percent of all housing units available in a given allocation area for non-elderly families are to be designated and accessible to the physically handicapped under this program. Rent is subsidized by HUD and requires tenants to pay up to 25% of their adjusted income.

The loan money from HUD is used to pay off bonds and notes - money raised by PHA's for the acquisition of building of homes and the maintenance of operating expenses. The following three methods are the most frequently used in acquiring homes:[10]

1. Acquisition. The PHA buys existing housing from the private market.
2. Turnkey. The PHA solicits bids from private developers to plan and construct housing which the PHA will purchase upon completion.
3. Conventional. The PHA acts as its own developer by purchasing a site, drawing up plans, and then soliciting bids from private firms to construct the housing.

Eligibility for Low Income Public Housing assistance includes low income families, individuals over 62 years of age, the handicapped, the displaced, or the remaining member of a tenant family. Local PHA's set the standards for eligibility requirements and applications can be made through these offices or through the state housing authority.

The disabled are included under eligibility requirements even though they are not directly indicated as such. Because PHA's receive federal monies they are required under Section 504 of the Rehabilitation Act of 1973 to open their programs to the disabled.

FmHA Section 502

Under Section 502, low-to-moderate income families, the elderly, and the handicapped can apply for loans to finance the construction, purchase, or repair of homes. To be eligible for assistance, families must reside in rural areas or towns that lie outside of major metropolitan areas and have populations between 10,000 and 20,000. Veterans or deceased veterans' families are given preferential treatment when applying for Section 502 assistance.

The loan money is flexible in that it can be used for a variety of needs, such as:[11]

-to buy, build, improve, repair or rehabilitate rural homes;
-to provide adequate water and waste disposal systems;
-to modernize homes by adding bathrooms, central heating, modern kitchens and other improvements; and
-to make homes accessible to the handicapped.

Section 502 loans cover 100% of the appraised property value as established by FmHA. Sponsors or eligible families are given a maximum of 33 years to repay the loans. Application for such loans can be made through the county office of FmHA where the housing is currently located or is to be constructed at a future time.

FmHA Section 504

Section 504 assistance is available to low income rural homeowners who occupy dwellings on farms or non-rural farm tracts. These loans or grants are used only for essential housing repairs and improvements. Construction is not covered under Section 504, nor is home improvement for appearances only. Elderly applicants are awarded combinations of loans or grants for the total cost of repairs. However, their income must be low enough so that only a portion of the amount can be repaid at any given time in order to qualify for assistance. Under section 504, homes cannot be sold for a period of 3 years.

As with Section 502, application for Section 504 is made through the county office of FmHA where the housing is located. The family must submit information for review on the condition of their home to the FmHA county supervisor. The county supervisor then visits the dwelling, assesses the need for assistance, and makes a decision within 30 to 60 days. The maximum amount guaranteed under Section 504 is $5,000.

Section 504 covers the following repairs and/or improvements: roof repairs; installations of storm windows, insulation, and heating systems; structural support repairs; room additions; and sanitary water and waste disposal installations. The handicapped can use this program to make their homes more accessible as well.

FmHA Section 515

Section 515 assistance is more comprehensive in that handicapped recipients are specifically included under eligibility requirements. Low-to-moderate income families and the elderly are also provided with funds without regard to income.

New regulations stipulate that congregate housing (i.e., group homes) is included for funding considerations under Section 515. For additional subsidies, Section 8 can be used in conjunction with Section 515, particularly for those families who cannot afford FmHA subsidized rent from their own income.

Section 515 loans can be used to:[12]

-buy and improve land on which buildings are to be located;

- provide streets, water, and waste disposal systems;
- supply appropriate recreation and service facilities and equipment;
- install laundry facilities and equipment;
- develop sites, including landscaping foundation planting, and construction of walks; and
- build, purchase, or repair apartments or similar multifamily dwellings in communities with populations of not more than 10,000 and...up to 20,000 people.

Eligibility requirements are also extended to individuals, private nonprofit organizations, public agencies, and consumer cooperatives.

Zoning for Alternative Living Facilities

Zoning is an important aspect of planning for the successful establishment of alternative residential facilities. Land use regulation is an area of great concern involving a wide range of laws that dictate usage of private property. For example, land use regulations may entail such measures as environmental controls, development and subdivision requirements, health and safety codes, sewage disposal requirements, and landlord-tenant laws which include an enormous barrage of regulations governing the private and public use of land.

Zoning is one area that falls under the domain of public regulations. Another closely paralleled mechanism used for the regulation of public land is comprehensive land use planning. Zoning is often viewed as the "blueprint" of the comprehensive or development plan. Zoning ordinances are the prevailing laws that govern land usage by private owners. The comprehensive plan is considered a general guide for the orderly growth of future developments. A report from the Illinois Association for Retarded Citizens (1980) defines zoning as:[13]

> ...the process of dividing up a given community into various districts or "zones," and ascribing a certain classifying symbol to each district (such as R1, R3, I2, C5, etc.). These symbols represent the statutorily defined types of activities which may be carried on in a district so designated...R1 through R3 may refer to "single family detached family dwellings," while C1 through C5 may describe certain "commercial" enterprises which may be conducted in zones so designated.

Land use regulations have caused substantial problems for service providers who wish to set up group homes in restricted zones. The following discussion will focus on restraints used in the past by plaintiffs and possible defenses that can be used by service providers in case action is brought against them by neighborhood associations.

The two most widely used restraints on the development of community-based residential programs are restrictive covenants and nuisance lawsuits.

Restrictive Covenants

Restrictive covenants are promises made by parties governing how a property may be used. The two distinct types of covenants are personal covenants and real covenants (i.e. "run with the land"). Transactions affecting personal covenants are between the current parties involved with the property in question. Should the property change hands, the third owner is not subject to those conditions set in the original transaction. Real covenants are more permanent in that subsequent owners are in fact subject to the rights and obligations originally agreed to prior to ownership.

Plaintiffs are on unsteady ground when they attempt to use restrictive covenants as their defense. Only those parties considered legal owners can enforce the terms governing the use of the property. However, litigation does occur as restrictive covenants take one or more of the following forms:[14]

(a) restrictions in deeds, subdivision plots, or homeowner association by-laws which limit the use of property to "family residential use," or simply "residential use," and thereby barring by implication uses of property which could be termed "commercial" or institutional";

(b) covenants which require only "single families" occupy the residence; a single family is usually defined narrowly in terms of blood relatives;

(c) restrictions which bar ownership of the subject property by charitable organizations or agencies, regardless of the exact nature of the program to be operated, or the clientele to be served.

Defenses

Service providers have three defenses in cases involving restrictive covenants. Because most cases of restrictive covenants involve the private use of land, the following defenses will target that particular area:

1. Only the legal owners of the property in question can sue on grounds of restrictive covenants.

2. Rule of free alienation. A long established principle of Anglo-American legal thought is that a basic and fundamental right of each individual is the right to freely acquire, hold, and dispose of property in accordance with the owner's private wishes. A subsidiary principle is that, while a person is legally in possession of property, that person has the right to use that real estate as he or she desires.[15] Service providers using this particular defense will find that courts usually favor the less restrictive use of land.

3. General property law principle. A court shall not enforce a private restrictive covenant if the enforcement thereof would impinge...on important public policy of state, or run contrary to a right or privilege granted by either the federal or state constitution or statues (See Garza v. Chicago Health Clubs, Inc., 329 F. Supp. 939; Barrows v. Jackson, 346 U.S. 249; or Shelly v. Kraemer, 334 U.S. 1). The two latter cases deal directly with restrictive covenants based on racial discrimination. In these cases, non-Caucasians were barred from use of private property and the courts ruled that the defendants' Fourteenth Amendment rights were in violation.

In Bellermine Hills Association v. Residential Systems (1979) an association of homeowners brought action against a company (Residential Systems) who located and leased residential property for the establishment of foster care facilities for mentally retarded children.[16] The homeowners sued the company on the grounds of private covenant for establishing a foster care facility in their subdivision, which they contend was zoned for single families.

The foster care facility was set up for six mentally retarded children who received direct treatment and care. Thus, the plaintiffs stated that the children and the foster care parents did not constitute a family, and were, therefore, in violation of the restrictive covenant doctrine which limited the type of structures in the particular subdivision to single-family residences. In this particualr case, the lower court reversed an earlier decision and ruled in favor of the service providers.

Nuisance Lawsuits

The nuisance doctrine has direct bearing on neighboring landowners. It states that no one can use one's property in any fashion that might cause injury to another person or property in the same locale. Applying this rule to particular cases is often vague and, at times, flexible. In many cases, the court's decision is based on an assessment of the landowner's use of the property as to how much harm the owner's neighbors actually incur. If the plaintiff feels that another person's property is hindering his own right to enjoy or use one's own private property, the plaintiff can sue on grounds of harm.[17]

In cases involving the establishment of group homes in particular residential areas, the plaintiff must prove either substantial harm, or the threat of substantial harm. Harm is very difficult to prove and mere conjectural harm is unacceptable in most cases.

The Restatement of Torts (1939) provides a discussion of determining the "gravity of harm" from an intentional point of view:[18]

> In determining the gravity of harm from an intentional invasion of another's interest in the use and enjoyment of land, the following factors are to be considered:
>
> (a) the extent of the harm involved;

(b) the character of the harm involved;
(c) the social value which the law attaches to the type of use or enjoyment invaded;
(d) the suitability of the particular use or enjoyment invaded to the character of the locality; and
(e) the burden on the person harmed of avoiding the harm.

In cases involving substantial harm, one factor plaintiffs often attest to is declining property value. Another factor, though more subtle, is community prejudice toward the characteristics of residents who are handicapped. Most courts will rule in favor of group homes if the service provider can prove:[19]

(1) that there is no real harm being done to neighbors by the residential program; and
(2) there is a high social value attached to the performance of these activities (programs).

As far as zoning restrictions are concerned, plaintiffs often use several tactics to bar the establishment of group homes in their particular neighborhoods. There are no specific classifications of property use for group homes. At best, most group homes are classified (for zoning purposes) under general categories such as nursing homes, homes for the aged, etc. Plaintiffs will often use this factor to their advantage. The Illinois Association for Retarded Citizens lists several tactics of which service providers should be aware:[20]

(1) the most desirable areas of many communities for residential living (and thus for the development of small group homes) are often restrictively zoned, making "single family dwellings" the sole permitted use in these portions of the community. In another section of the zoning ordinance, the term family is very narrowly defined to include only "biological families;" since the inhabitants of a group home are seldom related to each other, they do not qualify as a biological family, and thus are not permitted to live together in "single family" residence districts;

(2) some zoning codes specifically bar group homes entirely, or at least partially, from the most desirable neighborhoods.

(3) most zoning laws do not specifically provide for uses of property for group homes; when not specifically addressed in an ordinance, such group homes may be viewed by municipal officials as fitting into larger categories of uses,

are restricted to less desirable areas of the community, and are rarely permitted in single-family resident districts.

As mentioned earlier, the comprehensive plan is a futuristic document of land usage. The plan can serve as an outline for zoning code amendments and should be used to the service provider's advantage. Also mentioned previously is the fact that there is no specific category for small group homes with existing or developmental zoning plans. However, service providers work directly with zoning authorities to revise comprehensive plans or seek amendments to existing plans in favor of group home establishments.

At this point, the reader should obtain a general knowledge of the terms used to classify zoning codes. The following definitions are from the City of Lubbock, Texas zoning ordinances (1975).[21] However, these terms are flexible when applied to other areas.

Use: The purpose for which land or building is arranged, designed, or intended, or for which either land or building is or may be occupied or maintained. For example, a parcel of land can be used for industrial plants, commercial activities, residential purposes, etc.

Under the use category, the zoning code will include a "permitted use" classification. For instance, a permitted use of a "single-family" detached dwelling falls under a single-family district. Such a dwelling is occupied and used by a group of people who constitute a "family."[22] Other examples of permitted uses under a single-family district may include public parks, home beauty shops, day nurseries, etc. Permitted uses will vary from community to community. The service provider could establish a group home under such a classification depending on the intended purposes and general provision of each zoned district.

Non-conforming use: A use which lawfully occupied a building or land at the time (an) ordinance became effective and which does not conform with the use regulations of the district in which it is located.

Such classification is not included under the permitted uses of a particular district. A large apartment house, for instance, is categorized as a non-conforming use in a residential district because most apartment complexes often accommodate coin-operated vending machines, laundry services, pay telephones, etc. - all maintained for commercial use. Thus, a group home set up in a single-family residential district could possibly fall under the classification of "non-conforming use in a non-conforming building." A non-conforming building is a structure or building or portion thereof lawfully existing...which was designed, erected, or structurally altered for a use that does not conform to the use regulations of the district in which it is located.

Variance: A variance is a special permit to violate the law.[23] Certain non-conforming structures and uses may not totally comply with a particular zoning ordinance, yet they fit the intended purposes of the zoned district. If such a situation arises, municipal authorities will grant a variance and will not seek to enforce the exact requirements of the zoning code in the particular instance.[24] However, the service provider must keep in mind that a non-conforming use is considered a tolerated exception; whereas, a planned variance must be approved by the appropriate legal authority. As a general rule, the holder of a variance can freely make alterations and additions, suspend operations, or do anything else, so long as he or she stays within the scope of the variance granted, including any conditions which may have been attached by a board of appeals.[25]

In cases involving variances, most boards of adjustment will hold to the following rules:[26]

1. There must be a showing of hardship based upon unusual conditions in the size, shape, topography, or orientation of the property.
2. The unusual conditions must be peculiar to the property in question or to not more that a few properties in the zoning district.

3. The hardship alleged must be on the property itself. Personal hardships caused by other factors are not to be considered.

4. The hardship must not have been self-created by the present owner or by any previous owner subsequent to the effective date of the zoning regulations in question.

5. It must be clear that a literal application of the regulation would deprive the owner of a reasonable use of the property.

6. The relief granted should be only what is sufficient to permit a reasonable use.

7. The relief granted should not cause substantial detriment to nearby property or to the public good.

8. Under no circumstances should a variance be granted for a use or structure not otherwise permitted in the zoning district in which the property lies.

Special Use: A special use is an exceptional use, which by itself is not permitted under the principle use category, but is granted permission by a municipal official or agency. Most special use cases involve public hearings (as do variances) where applicants and resistant neighbors can present their evidence pertaining to the special use of group homes. Decisions are based on the following criteria:[27]

1. There is an important public necessity for the special use which the applicant proposes.

2. The proposed special use will not be detrimental to the public health, welfare and safety of the community.

3. The proposed use will not cause harm to those living near-by, nor cause a substantial diminuation of neighboring property values.

4. The special use will not seriously alter the essential character of the area in which it is to be located.

5. No other suitable site is reasonable or practically available for the proposed special use.

6. Necessary services (sewage, drainage, water, etc.) are already available for the special use.

Service providers must be aware of the fact that in special use cases most denials of applications are direct results of substantial opposition from neighbors, usually due to community prejudice toward the mentally retarded.

Exclusionary Zoning: Traditionally, exclusionary zoning has meant the discrimination of poor people or racial minorities by the use of zoning ordinances. According to Hinds (1979), exclusionary zoning helps to polarize society, strengthening the separation between the affluent and the deprived.[28] It is extremely important for the service provider to be aware of this tactic as it has been used in recent times to keep alternative living facilities out of restrictive zoned areas. According to Crawford (1979), the U.S. Supreme Court has held in many cases, that a zoning ordinance does not violate the U.S. Constitution merely because it operates to keep minorities and low income groups out, and that to invalidate an ordinance on such grounds it must also be shown that there was a deliberate exclusionary intention.[29]

Public Hearings

The processes involved in public hearings may strongly influence the placement of residential facilities in neighborhoods where there is substantial resistance. The service provider must have an array of facts and arguments to promote his side of the issue before he enters a public hearing. Hinds lists several rules to keep in mind:[30]

1. Select the right property that meets your needs...
2. Consider alternative sites to buy if it is impossible or not feasible to rezone the first choice.
3. Study the zoning restrictions before signing a binding contract.
4. If the property must be purchased, minimize risks by making sure that the property can be put to some other use or sold...if rezoning is not won.
5. Study the local procedures for rezoning in the ordinance. Ask the clerk or other appropriate knowledgeable person as to procedures and local customs that may not be written down. Consider the possibility of hiring a local attorney who is expert on these matters.
6. Consult local planners and zoning officials to determine possible problems in seeking a zoning change.

7. Consider if it is possible to accomplish the development objective (listed as the purpose for zoning uses in most ordinances) without seeking a rezoning (as, for example, a modification of the proposed project to comply with a liberal interpretation of the rules by the zoning administrator).

8. Talk to neighbors and neighborhood civic organizations to determine support of, or opposition to, the proposal. It may be possible to achieve some compromise in advance of a hearing.

9. Estimate the odds of winning a rezoning at the public hearing on the basis of input from the planners and neighbors with whom the proposal has been discussed.

10. Prepare a well-researched and locally supported presentation for the hearing. Coordinate the presentation with appropriate experts who have been hired. Make sure that all exhibits are clear and that equipment used to make the presentation has been tested in advance of the hearing.

Service providers should keep in mind that a coalition of resistant neighbors will often protest the establishment of residential programs in their district because they wish to preserve the essential characteristics of their neighborhood. All efforts should be made to keep these characteristics intact. However, concerned neighbors may raise the following pertinent questions:[31]

1. Would property values decline?

2. Will there be a highly transient group moving in and out?

3. Will the number of people or traffic density increase?

4. Will my property or my children be safe from harm?

If the service provider cannot avoid a hearing, he should have a good working knowledge of the oppositions' facts and arguments. According to Crawford (1979), the opposition will often stretch the facts in their favor. If this is the case, the service provider should try to find out what defense the opposition is planning to use.[32] Here, the strategy is to meet the opposition with convincing proof. For example, if a neighborhood coalition testifies that the establishment of a group home in their district would lower property values, the service provider could reveal proof that other successful residential programs in similar districts have not substantially lowered property values. Such proof may take the form of study results, photographs of homes with attractive grounds, etc. In most cases, the burden of proof is on the applicant filing for a variance or appeal.

Land Use Regulations

According to Breslin et al. (1980), neighborhood opposition is powerful for two reasons: (1) because zoning officers and county or municipal officials are either elected directly or appointed by elected officials, and therefore, highly responsive to the public; and (2) because whatever the issue, a few negative forces tend to be more vocal and persistent than neutral or positive forces.[33] The two most prevalent ordinances that service providers must deal with in public hearings are single family dwelling ordinances and exclusionary zoning ordinances. These types of ordinances most often ban the development of group home facilities and, as a result, require public hearings before local zoning boards.

Public Hearing Process

The steps involved in the hearing process vary from state to state. However, a general description of these steps should aid the service provider in understanding the procedures. The following is generally based on examples of procedures contained in the City of Lubbock's zoning ordinance.[34]

Assumption: A service provider has applied for a variance in order to use an existing building in a residential district as a group home for 8 mentally retarded adults.

Step I: The service provider goes before the Zoning Board of Adjustment for a variance.

1. The Board receives applications for variances, as well as special exception (use) permits and/or appeals.
2. The Secretary of the Board of Adjustment sets up a public hearing.
    a. The applicant (service provider) is required to pay a fee

70

(in this case $75.00) to cover costs for advertising, publishing, and mailing notices.

b. Notice of the public hearing is sent to the applicant, those affected by the change, and owners of property lying within 200 ft. of the property in question. These notices are sent 10 days prior to the date set for the hearing. The local newspaper(s) is informed 15 days prior to the hearing date.

c. The service provider and the opposition present their facts and arguments at the hearing.

3. A special exception is granted if the Board finds:

   a. That the granting of such exception will not be injurious or otherwise detrimental to the public health, safety, morals, and the general welfare of the general public, and;

   b. That the granting of such variance will not be detrimental to the public welfare or substantially or permanently injurious to the property or improvements in (the) zone or neighborhood in which the property is located, and;

   c. That the granting of (the) variance is necessary for the reasonable use of the land or building and that the variance as granted by the Board is the minimum variance that will accomplish this purpose, and;

   d. That the literal enforcement and strict application of the provisions of (the) ordinance will be preserved and substantial justice done.

   e. Again, the Board will consider the character and use of the buildings in the neighborhood in question, as well as the number of residents living or working in the building and the traffic conditions in the vicinity.

Appeal from the Zoning Board of Adjustment

Assumption: The Board votes unfavorably for the variance and the service provider decides to appeal the decision.

Step II: The service provider presents a petition to a higher court of law that specifies the illegality of the Board of Adjustment's decision. The petition must be presented no more than 10 days after the hearing.

1. The court directs the Board of Adjustment to return the original record of the case for review.

2. The court may either reverse, affirm or modify the decision brought up for review. If the court affirms the Board's decision then the service provider could request an amendment to the text of the ordinance or a change in zoning.

Changes and Amendments

Assumption: The service provider decides to request either an amendment or a change in zoning.

Step III: The service provider submits his proposed changes to the Planning and Zoning Commission.

1. The Planning and Zoning Commission holds a public hearing on all proposed changes. In this case, the service provider wishes to establish a group home in a single family neighborhood. He wants to change the zoning code in an attempt to block discrimination efforts to prohibit or restrict the development of group homes in the most desirable areas (in this case, single-family detached dwellings).

2. After hearing both sides of the issue, the Planning and Zoning Commission can either:

   a. Recommend against the change in zoning.
   b. Recommend the change in zoning.
   c. Recommend a change in zoning together with recommendations for requirements for the paving of streets, alleys, and sidewalks, means of ingress and egress to the public streets, provisions for drainage, parking spaces and street layouts and protective screening and open spaces and any other requirements, which within the judgement of the Planning and Zoning Commission will protect adjacent property and secure substantially the purpose and objectives of the zoning ordinance.
   d. The Planning and Zoning Commission's recommendations are sent to the City Council and the applicant is notified of the action.

Procedures Before City Council

Assumption: The Planning and Zoning Commission recommends against a change in the code.

Step IV: The service provider appeals the decision to the City Council. His appeal must be made no more than 30 days after the Commission's decision.

1. Before the City Council takes action on the Planning and Zoning Commission's recommendations, a public hearing is scheduled and all involved parties are notified.

2. A change in zoning must carry 3/4 of the Council's votes in order to become effective. In this case, the Council has the final power to accept, reject or make other or additional requirements before an amendment becomes effective. In many states, if the amendment or change is rejected, the service provider has the option of appealing to higher courts of law (i.e., district courts).

Graphically, the procedures would appear as follows:

Service Provider applies for a permit

The Zoning Administrator raises questions

Service Provider meets with the Zoning Administrator

The Zoning Administrator denies the permit

Service Provider appeals to the Board of Adjustment

Neighbors are notified of the date, time, and place of a public hearing

Board of Adjustment holds a public meeting and votes on the Service Provider's appeal

If the vote is unfavorable, the Service Provider appeals to the Planning and Zoning Commission

The Planning and Zoning Commission makes recommendations and sends them to the City Council

The City Council holds a public hearing and votes on the final recommendations

In Lubbock, the Building Inspector issues permits. However, the Administrator of the Zoning and Environmental Control Department must review all plans before a permit is issued.

The titles and responsibilities of zoning administrators vary from state to state. Generally, the administrator's main function is to interpret an ordinance when questions are raised (i.e., as to the establishment of a group home in a restrictively zoned area).

Strategies for Overcoming Restrictive Zoning

Establishing normal community settings for persons with handicaps is a key environmental factor often hampered by neighborhood resistance. Overcoming this resistance is at times one of the most frustrating aspects of setting up residential programs for persons who are mentally retarded.

As mentioned earlier, community groups will use mechanisms such as restrictive zoning as their edge to keep "them" out of the neighborhood. Meetings with local zoning boards often have negative overtones. A well organized service provider must be ready to meet the challenge with counter strategies for the successful placement of group homes in normal community settings.

It has been found that the strongest resistance comes from highly cohesive, well-established, homogeneous neighborhoods. As a rule, urbanized areas which are highly transitory and heterogeneous provide the least resistance but are not the most desirable community settings for group homes. To obtain the most desirable setting, the service provider in essence must become a public relations liaison between his agency and the community. Resistance can be overcome if key people from the community (i.e., officials, church leaders, prominent businessmen, etc.) are singled out and turned into proponents of the cause. This strategy has been found to work well in highly cohesive, resistant neighborhoods.

For highly transitory, urbanized areas, maintaining a low profile appears to be the best defense against neighborhood resistance. Most group home administrators have found that if such a facility is quietly established, the community will show little or no resistance. The fear of anticipation so common in long established, older neighborhoods is essentially eliminated as residents of the group home are integrated into the community. Judgement is reserved as the program gains merit through its successful operation.

As public relations liaison the service provider is faced with educating the community prior to establishing a group home. Because of a common fear of the unknown, the following section underscores the most commonly asked questions community members have regarding persons with severe handicaps. The question and answer format will give the service provider an idea of what he or she is up against in educating the community.[35]

1. Who lives in the residence?

Depending on the size of the house, anywhere from four to ten retarded persons, and a resident house-manager couple. The residents have been carefully screened and selected for their ability to live productively and responsibly in the community. No one is accepted in a residence who is not ready for it and able to operate at least semi-independently. Most of the residents have come from large State institutions, and this may be their first chance to live as productive, respected members of society. Very often these people originally came from the community in which the house is located. The residence program may be the most important opportunity of these peoples lives. They deserve the chance.

Although most group homes are established for mildly retarded people who function semi-independently on their own, there are residential facilities that house the severe to profoundly retarded. These residents are under constant supervision and are never left on their own as they function as a group on public outings.

2. What kind of supervision do the residents have?

The house-manager couple, some relief staff, and a Director, and other professionals. Most houses are legally incorporated and are monitored by a board of directors.

3. What do the residents do during the day?

Many of them work at regular jobs - as gardeners, dishwashers, laundry workers, waitresses, clerks, janitors, and a hundred other jobs. Retarded people are excellent workers-reliable, dedicated, enthusiastic, and proud. Those residents not yet capable of competitive employment, may work in a sheltered workshop (for which they are paid in accordance with their production), receive vocational training, or attend a day activity program to develop their intellectual and social skills. Children and younger residents attend local schools or receive special education in other settings. Every resident is involved in a full-time activity outside the residence.

4. What do the residents do with their leisure time?

They spend their evenings and weekends pretty much as everyone else does - watching television, going shopping, going to the movies, fixing the house, swimming, bowling, visiting friends. Nothing exceptional - but for someone who has lived in a big institution for years, it's a whole new world.

5. Aren't retarded people more likely to be involved in criminal activities? Aren't they more violent and irrational?

In one word: no. Frequency of arrest, crimes of violence, drug abuse, and other anti-social behaviors are no more common among retarded persons, than among any other segment of the general population. If anything, retarded people are less likely to get involved in anything criminal because they are extremely eager to be accepted and respected as full adults and responsible citizens.

6. Won't the community residence lower property values in my neighborhood?

There is no reason why it should. Homes, either bought or rented for use as Community Residences are kept in extremely good repair and meet all safety and fire standards; property improvements are frequently made. The residents are responsible people who can be an asset to their community. They are not destructive to property or to other people. In communities where residences have already been established, such initial fears and anxieties have proven goundless. The residence should be a welcome addition to any neighborhood.

7. But, won't more residences or other facilities of the same kind start to move into our town as well?

Not very likely. The Department of Mental Health has certain conditions for funding a community residence, two of which are that no residence can have more individuals in it that can be absorbed into existing neighborhood facilities and activities and that residences must be geographically distributed so that residents are assured of adequate services from available community resources. It is in no one's interest to move in on a neighborhood with several facilities when the community cannot accommodate them. It has not happened and it is extremely unlikely that it will happen.

8. Why can't these people be kept in institutions? Isn't it better for them?

"These people" don't like to live in institutions any more than you or I would. They want, and need the chance to grow, learn and develop to their fullest potential and they can only get that opportunity in the real world, in the mainstream of society. Separating retarded people, "putting them away" only serves to increase the problems as it would for any disadvantaged group. We now know that social factors (neglect, lack of stimulation, emotional deprivation) can contribute significantly to the condition known as mental retardation.

Retardation is not an incurable disease whose victims should be isolated and treated as something less than human. It is a condition that can occur in any family anywhere. The label "mentally retarded" tells us nothing about people, who they are, what their hopes and dreams are, nor their style of living in this world. Retarded people have the same inalienable rights to life, liberty and the pursuit of happiness as do all citizens in a free society. We cannot exclude them from those rights.

As far as the issue of their own safety, there is another right to which retarded people are entitled: the right to take risks. Treating a grown-up person like an eternal child who is never allowed the freedom to make choices, never held responsible for the consequences of actions, never able to succeed or fail by his or her own efforts-is to deny that person some of the deepest satisfactions of independence and adulthood. Certainly, it is safer to remain inside, behind closed doors, never risking a single step, but who among us would wish to stay that way?

9. Isn't the community residence costly to the taxpayer?

Not in the long run. Two hundred fifty thousand mentally retarded people now reside in public institutions at an annual cost to the U.S. taxpayers of well over one billion dollars. Probably half of those people could be returned to the community through programs such as community residences. Many of them will eventually be able to enter the competitive employment world, earning over $3,000 per year on the average, supporting themselves either fully or partially, and contributing their energies and talents to society. The de-centralization of services - that is, using local medical, dental, mental health, and social services - represented by the creation of small residential homes for retarded people, instead of huge, distantly-located institutions, is another money-saving aspect of the program. Furthermore, community residences provide income to the communities in which they are located when the residents purchase food, clothing, furniture, and spend money for recreation.

10. What problems are people in a new community residence likely to have? How can I help re-integrate retarded people into my community?

Retarded people who have lived for many years in large, impersonal institutions may have difficulty speaking to people they don't know. They may dress poorly because they have never learned what is appropriate to wear. They may have trouble getting the right bus, or finding a particular street or building. They may be taken advantage of by others who recognize their unfamiliarity with customary prices, business practices or social procedures. You can help by treating your new neighbors with kindness, consideration, and respect.

Another strategy for overcoming restrictive zoning is direct involvement of the news media. Chances are that the local media will become involved whether or not they are informed of the program. To avoid bias in reporting, inaccurate information, and/or incomplete information on the part of the media, service providers should make it a policy to keep the local news media informed of their plans in an attempt to gather public support of their project. One very effective tool used to inform the media is the formal press release. Of course, the service provider's purpose for writing a press release is to influence the local news media to write favorably about the residential program.

According to Seitel (1980), news editors are under such pressure to meet deadlines, they simply do not have time to wade through the masses of self-serving propoganda which they receive. Editors are looking for news.[36] To avoid unnecessary delay and to insure that the press release is used, the service provider should keep the following points in mind:

1. The format should be consistent and include: a heading; the name, address, and telephone number of a contact person; a release time and date, short paragraphs (no more than six lines); and should be less than two pages in length.
2. The release should adapt the pyramid style used by newspapers and magazines. Place the lead or most important facts at the beginning of the news story and follow with items in decreasing order of importance.
3. The content should contain newsworthy material, should be credible, should get to the heart of the issue and should avoid wordiness. Also it is essential that the content include the five W's and H: Who, What, When, Where, Why, and How.

Besides the press release, Breslin (1980), lists several other options that the service provider might find useful when dealing with the news media:[37]

1. The Editorial represents a viewpoint of the newspaper based on conclusions drawn concerning the significance of an event. Editorials are very effective in helping or hindering, the formation of public opinion to bring about change.
2. Feature Stories offer the greatest opportunity for in-depth exploration of topics of interest. Here the agency can provide the interested journalist with human interest stories: quotes from developmentally disabled people themselves, observations from a visit to a group home, background information on the nature of developmental disabilities, etc. Feature stories are potentially a great opportunity for community education.
3. Letters to the Editor are useful for rebuttal of recent unfavorable news stories or editorials. They should be short and concise, addressing misunderstanding or mis-quotes. Letters to the editor may also be used to support favorable articles.

The local news media can be a powerful influencing agent on existing community pressure. The service provider should try to keep open lines of communication with the local media and involve them in every step of opening a facility.

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CHAPTER IV

Determination of Population Needs

Federal Standards for Accessibility

In 1968 the Federal government passed the Architectural Barriers Act to enable handicapped persons accessibility to public buildings, and thereby allowed them the same rights and opportunities for gainful employment afforded the nonhandicapped. The watchdog for this legislation was the Architectural and Transportation Barriers Compliance Board (ATBCB) established under Section 502 of the Rehabilitation Act of 1973 to assure that standards were maintained under the Architectural Barriers Act. The service provider should note, however, that the ATBCB utilized a few of the technical specifications of the 1980 American National Standard Institute (ANSI). The ANSI is a private institute not affiliated with the federal government. The Institute's standards were formulated to guide manufacturers, consumers, and the general public in making buildings accessible to the disabled, and, it is the ATBCB that investigates complaints and discrimination claims in regards to architectural and attitudinal barriers to public buildings and monuments, parks and park land, public transportation systems, and residential and institutional housing. They also conduct research to find better ways to meet the needs of the handicapped. The service provider may want to review both standards for making building alterations and/or building new facilities for his residents. Write to the following addresses for additional information:

American National Standards, Inc.
1430 Broadway
New York, New York 10018

Office of Technical Services
U.S. Architectural and Transportation
Barriers Compliance Board
330 C. Street, S.W., Room 1010
Washington, D.C. 20202

Since the ATBCB's standards are federal regulations and requirements, they should be used as ancillary material since some of the standards differ in scope and technical specifications. These guidelines contain provisions for the most common elements and features of facilities and are composed of five major components:[1]

-Subpart A: General purpose, applicability, definitions, relationship of the guidelines and requirements to the Architectural Barriers Act standards, other uses and the effects of state and local laws on the guidelines.

-Subpart B: Waivers and Modifications. This particular section has been reserved as several commentators felt the provisions contained in Subpart B were too liberal and would thus result in non-compliance to the standards. Others felt the provisions were too restrictive of the rights of agencies setting the standards under the Architectural Barriers Act. As a result of the controversy, the ATBCB determines waivers and modifications of facilities on a case-by-case basis.

-Subpart C: Scope (description) of provisions and guidelines. Those provisions given careful consideration by the ATBCB include parking and passenger loading; elevators; the number of entrances; accessible doors, windows, toilet and bathing facilities; two-level drinking fountains and water coolers; alarm systems, tactile warnings and information cues; accessible telephones and communication devises for the deaf; seating, tables, and work surfaces; and accessible storage areas.

-The service provider may want to pay particular attention to Sections 1190.32: Additions and 1190.33: Alterations when making additions and/or alterations to existing buildings. These sections contain provisions for entrances; accessible routes; toilet and bathing facilities; elements, spaces, and common areas; alterations involving more than 50% of the full and fair cash value of the existing facility; power driven verticle access equipment (i.e., elevators); structural changes to stairs; and informational signage.

-Subpart D: Technical provisions (pictorial representations with required measurements). Subpart D contains technical provisions for clearances and equipment location (i.e., moving wheelchair clearances, reach limitations, etc.); walks, floors, and accessible routes (i.e., clear width for continuous passage, accessible routes around obstructions, protruding objects that make maneuvering difficult, changes in level, etc.); parking and passenger loading zones (i.e., locations of accessible parking and passenger loading zones, provisions for accessible parking spaces, adjacent access aisles, passenger loading zones, vertical clearances at accessible parking spaces and loading zones, appropriate signage reserving accessible parking spaces and identifying passenger loading zones; etc.); provisions for ramps and curbs (i.e., slopes and rises, width, cross-slope surface, curb ramps, etc.); stairs (i.e. provisions for risers, the projecting edge of the step, handrails, stair treads, and loading surfaces etc.); handrails (i.e.; provisions for size, spacing, height, etc.); elevators (i.e., provisions for operation and leveling, door operations, travel distance and door timing, reopening devises, elevator cars, control panels, control locations, door jamb markings, audible and visual car position indicators, etc.); platform lifts; entrances; doors (i.e., provisions for double-leaf doorways, revolving doors, sliding doors, clearing width, maneuvering space, etc.); windows; toilet and bathing facilities (i.e., provisions for clear turning space, signage, accessible toilet fixtures, toilet stalls, bathing facilities, grab bars, etc.); drinking fountains and water coolers (i.e., provisions for clearances, spouts of drinking fountains and water coolers, controls, etc.); controls and operating mechanisms (i.e., provisions for location, operation, reach limitations, etc.): alarm systems both visual and audible; tactile warnings; signage (i.e., provisions for character proportion and contrast, raised and incised characters, mounting, location, and height, etc); telephones (i.e., provisions for clear floor or ground space, equipment characteristics, equipment for hearing impaired people, etc.); seating tables, and work surfaces; assembly areas (i.e., provisions for size and location of viewing positions, listening systems, etc.); and storage.

-Subpart E: Special Building or Facility. This particular section is reserved for guidelines and requirements of special use categories. The Department of Housing and Urban Development is presently involved with the ATBCB in developing minimum guidelines and requirements for residential structures which include specific technical provisions for making residential facilities accessible.

Financial Assistance

Financial assistance for renovation or construction can be obtained through one major source - the Department of Housing and Urban Development (HUD). HUD sponsors a number of programs that may meet the service provider's needs for renovating existing facilities or constructing accessible facilities for his/her client population. Local housing authorities and agencies are also excellent sources to contact for such assistance. For those who have no experience with the "ins-and-outs" of the housing industry, it might be wise to hire a housing consultant before applying for assistance. The service provider might consider the following HUD funding sources to fit his/her needs.

Section 106(b)

HUD's section 106(b) program is useful for "seed money" or the initial outlay of money required to begin a project of considerable magnitude. The sponsoring agency receives a loan reservation which covers the preconstruction cost of building a home for its client population. Such costs could possibly include acquiring a site(s), hiring an architect to do preliminary blueprints, hiring housing consultants, etc. Section 106(b) pays up to 80% of the eligible start-up costs, and the sponsoring agency is responsible for the other 20% which must be spent before any loan money is released.

Section 312

HUD's Section 312 provides low-interest loans for home improvement to rehabilitate existing single-family or multi-family residential property for sites designated as revitalization areas (i.e., those sites designated for improvement through federal funds). The service provider can borrow up to $27,000 to bring the property up to local and federal housing standards. If the home is not located in a revitalization area, the service provider could use Community Development Block Grant money.

Community Development Block Grants - Title I

Under the CDBG program, local governments receive funds in the form of block grants for purposes of developing viable urban communities, providing adequate housing, and expanding economic opportunities for low- to moderate-income persons. Single- and multifamily housing (including group homes and halfway houses) are eligible for CDBG funds for purposes of acquisition, rehabilitation, and renovation. The funds can also be applied to surveys and plans for the removal of architectural barriers.

Home Improvement Loan Insurance (Title I)

Under Title I, the service provider can borrow up to $15,000 from private lending institutes for repairs and accessibility improvements to single-family dwellings. For structures that house two or more families, the loans can cover up to $1,500 per dwelling unit, not to exceed $37,000. The loans are insured by the Federal Housing Administration (FHA).

Section 231

HUD's Section 231 program provides mortgage loans to sponsors of rental housing for the elderly and handicapped. HUD insures the lending agencies against loss on mortgages. These mortages can be used for purposes of construction or renovation (and rehabilitation) of detached, semi-detached, or elevator-type rental housing of eight or more units.

Section 232

Section 232 is directed toward nursing homes and intermediate care facilities (ICF). The program provides federal mortgage insurance to help sponsors fund such facilities. The money can be used for purposes of construction or renovation of facilities that house 20 or more people. Equipment needed for the care of the residents can also be purchased under this program.

Section 235

Handicapped persons, families, or single persons qualify for Section 235 interest subsidies and mortgage insurance. HUD insures mortgage loans made by private lending agencies to private or public sponsoring agencies. The sponsoring agency then buys single-family houses, multifamily cooperatives or condominium projects, or mobile homes. After these units have been sufficiently rehabilitated, the agency resells them to low-income families. Such families have the added advantage of paying reduced interest since HUD provides interest subsidy payments under this section.

Accessible Features and Design Considerations

The location and structural design of an individual's residence greatly affect the stability and development of that individual, and environmental support enables the handicapped to help themselves, thus fostering feelings of independence. A service provider should consider site location as a critical factor when looking for an existing building to lease or buy. Sites with steeply sloping hills or pathways are impossible for the wheelchair user to negotiate. Also, sites located in rural settings make service areas difficult to reach.

The ideal facility should be structured in such a manner as to make the disabled individual feel as normal as possible without appearing as an institutional setting. Such a facility must fit or be adaptable to the individual's disability. For instance, doors should be widened to accommodate wheelchairs and bathroom fixtures should be located in easily accessible positions. Space allocation is another critical factor to consider when adapting a facility to the needs of the handicapped. Removing a wall to widen the size of a room aids freedom of movement and enhances independence for those who are wheelchair bound.

Costs for such renovations can be quite high, particularly for extensive work such as the installation of elevators, curb ramps, fire alarm systems or the relocation of bathroom or kitchen sinks for easier access. Other expenses incurred for special equipment, hardware and/or fixtures might include:

wheelchairs
variations in regular chairs
potty chairs
installing environmental control devises
standing and walking aids
special eating utensils
home-making equipment
bathing aids
lever door handles
special bathtub construction
continuous handrail extensions
toilet grab bars
shower seats or chairs
bathtub seats
single lever lavatory faucets
relocating wall switches and outlets
hand-held shower
curbless shower
special shower construction
bathtub/shower combination

This list is far from complete, and there are numerous aids manufactured for ease of independent living by the handicapped. Even the simplest "gadgets" or environmental encounters (i.e., snowstorms, inaccessible city transit, etc.) the able-bodied take for granted can be a source of frustration for the disabled. For instance, people who are wheelchair-bound are constantly subjected to such barriers as narrow doorways, insufficient floor space, and inaccessible light switches, thermostat registers, and telephones. Two excellent sources of information about the various aids on the market include:

Self-Help Aids
Fred Sammons, Inc.
Box 32
Brookfield, Ill. 60513

The Green Pages
641 West Fairbanks
Winter Park, FL 32789

"Self-Help Aids" is a catalog which contains such products as special eating utensils, hygiene products, dressing aids, wheelchair accessories, communication devises, various types of reachers, clinical and evaluation equipment and products, home-making equipment, and recreational products. "The Green Pages," published quarterly, is another excellent source for news and information on self-help aids, products and services for the handicapped.

The service provider should also keep in mind that the needs of individuals do differ. A narrow doorway does not necessarily pose the serious problem for a moderately mentally retarded resident that it does for the individual confined to a wheelchair. A report prepared by HUD (1976) lists several guidelines for planning living environments for the severely disabled:[2]

1. Quadriplegics may be right- or left-handed either from paralysis or in the traditional sense. Layouts should be designed to permit approach and use by a right- or left-handed person.

2. One criterion for determining the choice of design features and hardware for the severely disabled user is the extent to which the item permits user independence. By determining the cost of each item at the programming stage, budget-induced trade-off decisions can respond to user needs as well as economic considerations.

3. An important connection exists between psychological health and the ability to operate in the environment with minimal aid. The more familiar the designer is with the severely disabled person's views and capabilities, the more likely that the resulting design decisions will produce an efficient and therapeutic environment that requires limited intervention by able-bodied staff.

There are various sources the service provider could turn to for expertise and advise in such matters: architectural firms, medical experts, physical and occupational therapists, social workers, carpenters, parents of handicapped children, and disabled individuals themselves. The following information is based on material compiled from design studies by the Veterans Administration (1978)[3] and Hud's findings on structural housing designs for the disabled (1976).[4] Most of these recommendations are intended for those persons who are wheelchair bound or who require some type of walking aid (i.e., braces, crutches, etc.). However, a few of the design considerations also apply to other disabilities that do not require wheelchairs or walking aids. It is also important to note that the Veterans Administration stresses the fact that each home will require a different degree of specialized design, and their recommendations are based on schematic arrangements of single-family dwellings; HUD's recommendations include more varied types of dwellings. The material presented below should alert the service provider to general areas that will require considerations in adapting a home to his client population.

1. Avoid sites with excessive sloping hills as extensive ramp construction would be necessary for easy travel access.

2. Sites with enclosed courtyards have the advantage of providing extra privacy and security. Courtyards should be large enough to accommodate a number of wheelchairs, and hard-surface decks, patios, and walkways, which are constructed with non-slip material are recommended for easy travel.

3. Direct access to the street and driveway is very important.

4. If ramps are necessary, a slope of 5% to 8% is recommended. Handrails should also be installed as balancing aids and as a means of propulsion for those in wheelchairs.

5. Stairs should have beveled or slanted risers, particularly for those individuals who wear braces.

6. The entrance should have a weather protective canopy or overhang.

7. A level platform should be provided at the entrance; door mats and/or vertical obstructions of more than 1/2" in height can cause problems for the wheelchair user.

8. Garages or parking spaces should be as close to the residence as possible for easy access. Routes to and from the garages, carports, and parking spaces, should be protected from inclement weather.

9. In general, all rooms should be large enough to allow freedom of movement, particularly for the wheelchair user, and to accommodate large pieces of

89

medical equipment (i.e., hydraulic lifts). Larger spaces give the wheelchair user adequate turning radius.

10. Maximum knee space should be provided under bathroom sinks, and all exposed water supply and drain lines should be properly insulated to prevent burns and scrapes. The Veterans Administration recommends that lavatories should be mounted at a maximum height of 2'10" for wheelchair users.

11. Bathroom floors should be constructed of non-slip material.

12. The bathroom arrangement should allow for easy maneuverability from the wheelchair to the toilet, tub, and shower, and grab bars should be installed for easy transfer. Keep in mind that transfer is easiest when the particular fixture is approximately the same height as the wheelchair seat.

13. Medicine cabinets, shelving, and other bathroom fixtures should be located at an easily-accessible position.

14. Mirrors should be tilted or lowered for easier viewing.

15. A single-lever faucet located at an accessible distance from the edge of the vanity should be installed.

16. Showers should not have curbs or thresholds to impede wheelchair access, and all shower controls should be easily accessible. A bench seat or shower chair is most commonly used, and a combination bathtub with shower controls can be installed to accommodate individual differences.

17. To aid wheelchair users in tranferring to and from the tub, platform seats should be located at the end of the bathtub.

18. Thermostatic controls should be installed to avoid sudden changes in temperatures.

19. Kitchens should contain labor saving devises (i.e., dishwasher, garbage disposal, self-cleaning ovens, etc.).

20. Accessible storage space is a necessity.

21. Cabinets should have adjustable shelving and lazy susans for easy access to kitchen items. Avoid high cabinets for clients who are wheelchair bound.

22. Appropriate knee space should be provided below the sink and work counter. As in the bathroom, insulate all exposed water and drain pipes to guard against burns and scrapes.

23. Wall-mounted ovens and counter-mounted burners are recommended for easier access. The Veterans Administration recommends a maximum mounting height of 2'10" for cooktops to allow the seated individual to monitor food while it is cooking. Also, cooking controls should be front or side mounted.

24. Wall-mounted ovens should be located at the ends of counters. This position makes it easier for the wheelchair user to approach the oven from the side.

25. Ramps are required for level change between rooms. It is recommended that single-story dwellings be specially adapted, particularly for wheelchair users.

26. Low-pile carpet is recommended for the wheelchair user; raised-nap carpets tend to get caught in the wheels and make movement a problem.

27. Avoid floors that constantly need waxing for upkeep.

28. Pressure sensitive light switches are recommended.

29. Height consideration for control switches is important. The Veterans Administration recommends that a maximum height for wall switches, wall outlets and telephones of 4'0."

30. Windows with heavy frames are hard to open, particularly for wheelchair users. The casement or hopper-type windows are the most widely used by people in wheelchairs. Window controls should be accessible and easy to operate, and the location of the window should take maximum advantage of light and outdoor views.

31. Avoid hard-to-work locks and/or latches.

32. The front-loading mailbox is the most accessible for wheelchair users; the traditional type makes it difficult to get letters that are to low in the box to reach from a sitting position.

33. Front-loading washing machines are more accessible for the wheelchair user.

34. Protective features such as "on call" communication systems allow the staff to be electronically in touch with the residents at all times in case of emergencies.

35. Visual privacy is very important to the severely disabled. For instance, the bathroom entrance should not be visible from the living room so that the wheelchair user has freedom to enter the bathroom undressed. Bathrooms should be accessible from the individual's bedroom.

36. Like windows, doors should require minimal strength to open and close. If the dwelling has traditional doors (doors that open into the unit), attach a rope or chain to the doors for ease in closing. However, if the budget allows, automatic doors are much easier to operate.

37. The Veterans Administration recommends use of door latch handles which are easy to operate. Vertical or horizontal pull handles on the trailing side of the door are the most widely used means of closing a door (for doors that open to the outside of the room).

38. Avoid excessively heavy doors as these types are particularly hard for the wheelchair user to operate.

The preceding design considerations are only a few suggestions for the service provider. For further information on what to consider in renovating a home for accessibility, the service provider should write to the following agencies:

Department of Veterans Benefits
Veterans Administration
810 Vermont Ave.
Washington, D.C. 20420

General Services Administration
18th and F Sts., N.W.
Washington, D.C. 20405

Office of Independent Living for the Disabled
U.S. Department of Housing and Urban Development
451, 7th Str., S.W.
Washington, D.C. 20410

Clothing

Clothing is another consideration in aiding the disabled to live as normal a lifestyle as possible. Houseparents should be aware of their clients' likes and dislikes in clothing styles and should aid in selecting the appropriate styles to fit the residents' needs. Houseparents should also assist residents in dressing appropriately for various occasions. Steinhaus and Richardson (1982) state that designs in clothing for the handicapped should simplify the task of dressing, hide abnormalities, and should help the wearer project a fashionable image. Problems in dressing come from limited range of motion, reduction in manual dexterity, loss of strength, or dependence on braces, wheelchairs, or prostheses; problems of apparel fit are thus further compounded by an inability to zip, buckle or button, and to reach, stretch or pull.[5]

An example of an easy-to-manipulate design feature is the self-adhesive fasteners which solves the problem of managing difficult buttons or zippers for those disabled people who have little or no finger manipulation or control (i.e., quadriplegic).

Kay Caddel, in association with the Textile Research Center at Texas Tech University, designed apparel that is considered adaptable to various types of disabilities. Such fashions include:

-jumpers designed to open at the sides with zippers; the front portion is open at the waistline, and the neck opening is easily accessible.

-dresses with front and yoke openings with elastic waistlines for ease in dressing non-ambulatory persons.

-jackets with two front-separating zippers; back pleats for extra room; and lapels with no collar.

-jeans with openings on each side; elastic waistbands, outside pockets, and front flies.

-wrap-around skirts and blouses for ease in dressing.

-jumpsuits with either front or back zippers and side openings.

-wrap slacks designed for persons in wheelchairs. The front portion hooks together in the back with an elastic band. Also, the back can be lowered or raised separately for comfort.

-wheelchair vests that fit around the shoulders, waist and crotch areas; the vest fastens in the back of the chair.

-utility lap trays made of material that enables a paraplegic or quadriplegic to handle hot or cold items with no danger. This particular item has rolled edges to keep items on the user's lap; the tray can also be used for sewing or any other activity which requires a flat surface to work on.

-utility tote bag which hooks on to the wheelchair and can be used to carry kitchen utensils, books, supplies, etc.

These designs can be found in a pamphlet entitled Pattern Designs for the Physically and Mentally Handicapped offered through the Textile Research Center at Texas Tech University. For further information write to:

Kay Caddel
Textile Research Center
Texas Tech University
P.O. Box 5217
Lubbock, TX 79417

Most companies that do carry specially designed clothing for the handicapped are mail order companies. The service provider may want to write to the following addresses to obtain information on what products are available.

Betty Butler, Inc.
P.O. Box 51
Tenafly, NJ 07670

CAPH Clothing
P.O. Box 22552
Sacramento, CA 95822

Caradine of California
P.O. Box 22754
San Diego, CA 92122

Care-Sew-Much Designs
1920 Sheely Drive
Fort Collins, CO 80526

Clothing Research and Development
Foundation, Inc.
P.O. Box 347
Milford, NJ 08848

FashionAble
Rocky Hill, NJ 08553

Self-Help Clothing for Handicapped
Children
Easter Seal Society
2023 West Ogden Ave.
Chicago, IL 60612

Designs, Inc.
P.O. Box 364
Stillwater, OK 74074

I Can Do It Myself
3773 Peppertree Drive
Eugene, OR 97402

Kwik Sew Pattern Co., Inc.
300 Sixth Ave. North
Minneapolis, MN 55401

Sarah Soft Wear
1002 South Jefferson
New Ulm, MN 56073

Handee For You - Fashions for the
Handicapped
7674 Park Ave.
Lowville, NY 13367

Home Safety - Life Safety Code

One-half of all accidental injuries reported yearly occur in and around the home, and the same environmental encounters that the able-bodied deal with so readily can prove life-threatening to the handicapped. A few home hazards which service providers should be aware of include:

-loose rugs;

-polished, wet or greasy floors;

-poor lighting;

-lack of fire-fighting equipment, fire-detection systems, etc.;

-fire hazards from smoldering cigarettes, cooking, and heating equipment, faulty wiring, use of butane or liquid petroleum gas in floor furnaces, etc.;

-poisoning from household chemicals, medicines, etc.; and

-cuts from kitchen knives, tools, razors, etc.

A sense of security against these and other hazards is yet another factor that influences independent functioning. Standards have been established for the protection of residents in alternative living environments. Safety codes and regulations have been developed for fire safety, sanitation, health, and the environment. Such codes as the Life Safety Code of the National Fire Protection Association (NFPA, 1981)[6] are widely accepted and are used by sponsoring agencies for both accreditation purposes and safety measures for their residents.

Service providers should conduct careful investigations of their residents' home and pinpoint areas that could cause potential hazards. Listing hazards and possible precautions against such hazards can help the group home parent avoid potentially dangerous situations. Also, service providers should enlist the aid of local organizations for informal workshops and/or training sessions (i.e., the Red Cross, the local fire department and police department, nutritionists, local health clinics, etc.).

Of particular importance in cases of fire emergencies is the use of evacuation plans. The National Bureau of Standards (1980) lists several findings on behavior characteristics of the handicapped in fire emergency situations.[7]

-People in fire emergencies tend to use egress routes with which they are familiar. This suggests that building designs and management plans should encourage occupants to use fire-safe egress routes as a matter of course. Daily stair usage has been found to increase significantly, for instance, when stairwells are well-lit and attractively decorated.

-People with cognitive disabilities (such as those associated with mental retardation and senility) are able to learn and remember the location of stairs more easily if the stairwell doors they pass daily have vision panels that reinforce the often disregarded message of "Exit" signs.

-In many fire emergencies, the majority of time elapsed between the sounding an alarm and escape is spent interpreting the situation and deciding what to do. This not only confounds efforts to base fire-safety codes and standards on actual travel times, but also indicates the importance of providing effective, unambiguous alarms and pre-ignition egress instructions (i.e., evacuation plans).

-Studies of office towers and public assembly places indicate that people with a variety of handicapped conditions can evacuate down or up stairs along with everyone else without significantly impeding overall egress. Some, however, may need assistance (i.e., those in wheelchairs can be carried out by others).

The results of such behavior studies clearly indicate the value of fire safety planning for the handicapped. For instance, it is recommended that facilities provide two means of egress from each dwelling unit. One such means of escape should be through an unobstructed door or stairway to the outside of the building at street or ground level (Life Safety Code, 22-2.1.1). The second means of escape is through an outside window operable from the inside without the use of tools. The window must provide a clear opening of not less than 20 in. (50.8 cm) in width, 24 in. (60.96 cm) in height, and 5.7 sq. ft. (.53 sq m.) in area. The bottom of the opening should not be more than 44 in. (111.76 cm) above the floor (Life Safety Code, 22-2.2.1). The reason for providing two means of escape is to make an alternate route accessible if the resident is in an area of the building where the fire makes one of the routes inaccessible.

Many service providers find old, two-story homes ideal for their client population. These homes generally have wide, open staircases in the middle of the building, staircases which often act as flues that increase the intensity of a fire from the first floor to higher levels. Some means of closing off the higher levels is required for fire safety.

Other hazardous areas in the home include boiler and heater rooms, laundry rooms, kitchens, repair shops, handicraft shops, linen rooms, storage rooms or spaces used for storage (storage under staircases is prohibited), and trash collection rooms.

Another safety consideration is the interior finishes on walls which are classified according to flame spread test scales and smoke test scales. Interior floor finishes also go through classification tests. There are approved fire retardant paints or solutions on the market that can be applied to wall surfaces. Such paints and solutions must be renewed periodically, however, to maintain the necessary fire retardant properties.

Another important safety feature is the automatic sprinkler system. Most residential facilities, with the exception of patient health care facilities, are not required to have such a system installed. However, the incentives for installing a sprinkler system include reduced rates on insurance and tax deductions. Also, if the residence has an automatic sprinkler system, certain safety requirements can be modified. For example, most residences are required to have a two-hour fire wall (i.e., the amount of time a wall, door, etc. can resist fire). If the residence has an automatic sprinkler system, this requirement can be dropped down to a 20-minute fire wall.

Elevators are particularly hazardous during fire emergencies. The general rule follows that elevators should be closed down during fire emergencies, and other means of escape should be used. The dangers of being trapped in an elevator during a fire include serious injuries and/or fatalities. Automatic elevators tend to operate unpredictably during fire emergencies. The ANSI (A17.1, 1978) has established standards for the operation of elevators if their use during a fire emergency is necessary.[8]

Service providers should review standards and regulations such as the NFPA's Life Safety Code and the ANSI's technical specifications for safety planning purposes. The local fire marshall is another excellent source of information on fire safety instructions and procedures. The fire marshall has the responsibility of conducting inspections of health care facilities that house six or more people. Generally, local fire departments have their own evacuation plans and safety measures. The following evacuation and disaster plan is based on an emergency plan formulated for nursing homes and other health care related facilities in Lubbock, Texas. This information could prove of value to service providers who are planning safety measures and evacuation plans for their clients.

KEEP CALM - DO NOT SHOUT FIRE

I. FIRE

A. Discovery of Fire

1. The person finding the fire or smoke will immediately sound the alarm, notify the fire department and then the administrator.

2. If the fire is not easily extinguished, or patients are in immediate danger, remove the patients from the room and close the door.

3. Sound the manual alarm nearest to the fire - usually at or near EXIT doors.

B. Action

As soon as the alarm sounds, personnel assume duties as follows:

Charge Nurse

1. When the alarm sounds, either manual or detector, determine that there is an emergency and then:

    a. The statement "Dr. Pyro report to (room # and wing) immediately" will be used to alert personnel on duty by paging systems. Repeat statement 3 times.

2. Dial the fire department and, speaking clearly and slowly, give the following information:

    a. Location of fire - nursing home name and address stating distinct part of building the fire is located in, and nearest intersection.

    b. Size of the fire.

    c. What is burning.

    d. Name of person reporting.

    e. Stay on phone until you are sure the information is clear to fire department personnel.

3. Notify Administrator (if not on premises) or Director of Nurses. (The Administrator or Director of Nurses is in charge of an emergency until the Fire Department arrives. The Administrator will, by telephone, designate a person to notify off duty personnel to report to the facility to assist until the crisis has passed. If the Administrator cannot be located, the Director of Nurses assumes this responsibility).

4. Direct evacuation - in accordance to evacuation plan and severity of emergency - total or interior evacuation. Charge Nurse remains in charge until the Administrator or Director of Nurses arrives.

a. Prior to arrival of fire department PRIORITY OF EVACUATION WILL BE:

   1. Evacuate patients from affected room and nearest rooms.
   2. Evacuate patients from affected wing.
   3. Evacuate other patients as ordered.
   4. If an attic fire, evacuate all patients.

b. Removing patients from danger area:

   1. Ambulatory patients may walk, and should be removed first. See that charts go out with ambulatory patients, assigning a Nursing Assistant to stay with them outside, or in safe areas.
   2. People in wheelchairs or geriatric chairs should be removed second.
   3. One person (employee) can carry a patient on his back.
   4. Two people can make a pack saddle with their hands; have a patient sit on it and carry him out.
   5. Bed patients can be carried on a bedspread, blanket or sheet with the edges rolled as a stretcher. They can be carried by two people, or dragged by one. Never use the mattress. Remove bed patients last to avoid confusion. Roll the beds.
   6. When smoke and fumes are present - get patient as close to the floor as possible to move out.

Maintenance, Housekeeping, Laundry & Other Personnel

1. Shut off electrical system to prevent smoke from moving through return air ducts; then take extinguisher to site and fight fire if smoke and heat are not too intense.
2. Assist with lifting patients into wheelchairs. Aides can remove them from danger area as necessary.
3. Assist in rolling bedfast patients out of building on beds, when total evacuation is necessary.
4. All oxygen should be shut off and removed if possible.

Kitchen Charge Person

1. See that gas and electrical service is shut off in kitchen area.
2. Assist with control or evacuation of patients from dining area as necessary.
3. See that the kitchen and dining areas are closed off as needed.

Nursing Assistants

1. Be sure ambulatory patients get out, if necessary to move patients.
2. Assist in getting wheelchair patients out.
3. Assist in moving bed patients out on the beds.
4. Remain on unit assigned; stand by for possible evacuation unless assigned other duties by charge person.

Office Personnel

1. Safeguard records; remove them to a safe place.

2. After patients have been evacuated, attendants should check to see if all are accounted for. If not, notify the fire department.
3. In the event of complete evacuation, patients will be taken to (list other hospitals in the area).
4. Families of ambulatory patients will be notified as soon as possible to come for their relatives if they cannot be returned to their rooms.
5. Notify local DPW office.

C. Fire Prevention

1. The Administrator will make a complete tour of the home each morning to note any safety hazard and see that such is corrected the day found; keep halls free of obstacles.
2. Simulated drills will be held at least every month; include all personnel on all three shifts. A written report will be made showing persons assisting in the drill and signatures of all personnel participating in the drills.
3. Keep areas as free of combustible material as possible.
4. Waste paper, soiled linens, trash and records may ignite easily.
5. Report fire hazards to supervisor so that they may be eliminated.
6. Post "no smoking" signs and remind patients and visitors not to smoke in a room where an oxygen cylinder is located.
7. Smoking by personnel in designated areas only.
8. Patient smoking is allowed only under supervision.
9. Absolutely no smoking is allowed in storage, utility or work areas.
10. Be sure cigarettes are extinguished when discarded.
11. Telephone numbers of those persons to be called are to be posted at each telephone in the order they are to be called.
12. Every attempt will be made to prevent smoking in the resident's room.
13. It is the responsibility of all employees to be alert to the possibility of fire in the area where they work and each should do his part to prevent fire. It is also his responsibility to know his role in the event of a fire and be prepared to fill it.

As can be seen from the Lubbock County example, evacuation plans and safety measures must be spelled out to the letter. Each employee has assigned duties to perform during an emergency, and he is expected to fulfill those duties. Of course group home evacuation plans will not have as large a number of persons to deal with as do nursing homes or other health care facilities. Each community should have its own complete emergency and evacuation plans similar to the Lubbock County example. This information can be obtained from the local fire department or fire marshall. The NFPA's Life Safety Code (1981) is an excellent source of information on rules and procedures for making the residents' home a more safe and secure environment in which to live.

References

[1] National Bureau of Standards. Fire and life safety for the handicapped. Washington, D.C.: GPO, 1980.

[2] An evaluation of housing for the severely disabled: In the context of a service delivery system. Department of Housing and Urban Development: Office of Policy Development and Research, 1976, pp. 18-19.

[3] Handbook for design: Specially adapted housing. Washington, D.C.: Veteran's Administration, 1978.

[4] HUD, 1976.

[5] Steinhaus, N.H. & Richardson, G.R. A fashion special in Journal of Home Economics, Vol. 74, No. 4, Winter 1982, p. 37.

[6] National Fire Protection Association. Life safety code. Quincy, Massachusetts: NFPA, Inc., 1981 (revised).

[7] National Bureau of Standards, 1980, p. 36.

[8] Technical specifications from the American national standards institute (ANSI). New York, New York: American National Standards, Inc., 1978.

Chapter V

Development of Policies and Procedures

Client's Rights

"Before the law, all persons are created equal."

The goal of residential programs for persons who are mentally retarded is to allow each resident to live as normal and independent a life as possible, but the legal rights of residents in these programs have raised certain questions and issues. These rights include the right to liberty; the right to privacy; the right to treatment and habilitation services; equal educational opportunities; freedom from harm and abuse; the right to a safe and humane environment; the right to confidentiality and access to records; the right to marry; the right to medical services, advocacy services, and legal services; the right to vote; the right to live in barrier-free environments; the right to receive benefits under federal and state social programs, subject to eligibility; and the right to receive compensation for labor. These are the most fundamental and basic rights afforded all citizens, and they are specifically addressed in the U.S. Constitution as well as various state constitutions, federal and state statutes and policies, and court decisions. But other rights are also in question, and these include:[1]

- the right to send and receive mail.
- the right to enter into contracts and to own and dispose of property.
- the right to equal access to recreation and athletic programs.
- the right to choose and practice religion.
- the right to be free from culturally-biased and other improper testing and classification procedures.
- the right to reasonable and convenient access to make and receive telephone calls.

- the right to be free from medical experimentations.
- the right to clean and seasonable clothing.
- the right to criticize or complain about a program's conditions, employees, or practices without reprisals.
- the right to have and control personal possessions.
- the right to regular physical exercise.
- the right to adequate climate control in the form of heating, air conditioning and ventilation.
- the right to adequate sleeping quarters and furnishings.
- the right to adequate lavatory and bathroom facilities which provide for resident privacy.
- the right to sanitary and nutritious food in adequate quantities.
- the right to compliance with fire, sanitation, safety and health codes.
- the right to freely express oneself, whether it be through the choice of one's hair length, clothing styles, music, or otherwise.
- the right to be free from unjustified encroachment upon a normal lifestyle, life cycle, and age-appropriate activities.

According to Burgdorf (1980), these rights are not universal, nor are they applicable in every situation. Because they are statements of general principles, individuals in residential programs can assume to have these various rights. But the service provider must keep in mind that if other competing interests appear, these rights can be denied under proper legal authority, with appropriately compelling justifications, and in accordance with constitutionally adequate procedures.[2]

The rights of the handicapped are derived from and protected by six basic legal authorities:

- the due process clause of the 14th Amendment
- the equal protection clause of the 14th Amendment

- the right to privacy
- the Developmental Disabilities Assistance and Bill of Rights Act
- Section 503 of the Vocational Rehabilitation Act of 1973
- Section 504 of the Rehabilitation Act of 1973

The Fourteenth Amendment which includes both the Due Process Clause and the Equal Protection Clause states:[3]

"No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any state deprive any person of life, liberty, or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the law."

Due Process Clause

Burgdorf (1980) lists seven procedural standards recognized by the courts as the necessary prerequisites to confinement in a residential facility:[4]

1. Notice of the proposed confinement and of an opportunity for a hearing should include a description of reasons the confinement is believed necessary, dates and times of the proceedings, and a description of the procedural and substantive rights of the individual regarding the proceedings.

2. A formal hearing should provide an opportunity for the presentation of witnesses, testimony and other evidence as well as an opportunity to hear and to challenge opposing testimony and witnesses. In very unusual cases, the person whose confinement is sought should have a right to attend the hearing, although the individual has a right not to testify if he or she so chooses. The hearing must be held before an impartial, legally authorized tribunal, usually a court. The hearing should culminate in a formal decision which is based upon the evidence presented.

3. The person whose confinement is sought has a right to be represented by legal counsel, either at his or her own expense, or, if the individual is unable to afford counsel, at public expense.

4. The U.S. Supreme Court has ruled that the need for confinement be proven by the legal evidentiary burden of "clear and convincing evidence." The evidentiary standard is more stringent than the "preponderance of the evidence" standard used in most other civil contexts, but it is not as stringent as the "proof beyond a reasonable doubt" required in criminal cases. The justification for confinement which must be proven by "clear and convincing evidence" will generally consist of proof of a recent overt act or threat of dangerousness; it may also include proof of disability and a lack of alternatives to confinement.

5. A full record on the proceedings, adequate for review, should be compiled and maintained.

6. The decision of the lower tribunal should be appealable to a higher forum.

7. The U.S. Supreme Court has declared that the nature and duration of confinement must bear a reasonable relation to the purpose for which the individual is confined, and the confinement must cease if the reasons which justified it cease to exist.

In Texas, Article 5547-300 of the Mentally Retarded Persons Act (MRPA) governs the procedures for involuntary confinement of mentally retarded persons. Section 37(b) of this Act stipulates that no person can involuntarily be committed to a residential care facility unless:[5]

> (1) the person is mentally retarded;
>
> (2) evidence is presented showing that because of retardation, the person represents a substantial risk of physical impairment or injury to himself or others ...;

(3) the person cannot be adequately and appropriately habilitated in an available, less restrictive setting, and;

(4) the residential care facility does provide habilitative services, care, training and treatment appropriate to the individual's needs.

If placement in a residential care facility is deemed necessary, every effort is made to place the resident in the facility closest to his home. The mentally retarded person, his parent, legal guardian, or any other interested person may file an application of determination of commitment with the county clerk; this must be done in the county in which the mentally retarded person resides. The recommendations of a diagnostic and evaluation team and a summary report are to be included in the application. A hearing is then set to determine the appropriateness of the commitment. Evidence presented at the trial is based on the most current diagnosis and evaluation of the individual in question, and the party who filed the application must prove beyond a reasonable doubt that long-term placement of the individual is appropriate.

The Equal Protection Clause

The equal protection clause of the 14th Amendment demands that there be adequate justification for any state action which treats certain individuals differently from others; it does not, however, require that everyone be treated identically. This clause has been a major tool of the handicapped in their fight against discrimination.

Right to Privacy

Privacy is the right to be alone, and this right pertains to personal matters which include the right not to be watched, listened to, or reported upon without leave, and not to have uninvited public attention focused upon one.[6] Invasion of privacy encompasses many forms: intrusion into one's home or business, intrusion from unwanted publicity (by the mass media), intrusion from the use of surveillance devices, intrusion by the disclosure of private information (i.e., disclosure of client/counselor information), etc.

Wald (1976) states that under privacy laws, the individual who is handicapped is guaranteed "certain areas or zones of privacy" that are delineated in the Constitution.[7] These rights extend to activities which include the right to marry, the right to make contracts and engage in business and trade, the right to hold a job, the right to vote, the right to an education, etc.

In the area of privacy, perhaps one of the most important aspects is the confidentiality of personal records. Extensive record keeping on clients in residential programs is often necessary for medical reasons, for background information on the individual, for developing individual programs, for charting program progress, and for ICF/MR requirements. Service providers should be aware of the fact that disclosure of a client's records is necessary under certain circumstances. The general rule, however, is that all records, documents, and information on file in a residential program are to be kept confidential.

Access to records is another right guaranteed by the Constitution. The Freedom of Information Act provides access to federal records or records held by agencies of the federal government. Individuals can obtain or inspect copies of records with the exception of those records containing certain medical or personal information. However, the general rule follows that records on file in residential programs are confidential and may not be subject to public inspection unless the client, his parent(s) or gaurdian consent to allow disclosure of identifying information.

Statutes which govern confidentiality of client records in Texas include Article 5561(h) V.A.C.S. and Section 57 of the Mentally Retarded Persons Act.

Article 5561(h) stipulates that communication between a client and a professional is confidential and is not to be disclosed unless malpractice proceedings are brought by the client against the professional or when, in writing, the client waives his right to the privilege of confidentiality.[8]

Section 57 of the MRPA stipulates that records which contain the identity, diagnosis, evaluation, or treatment of any person and which are maintained in connection with the performance of any program or activity relating to mental retardation are to be confidential unless:[9]

- the mentally retarded person, his parent(s), or gaurdian give written consent to allow disclosure of any information within the records;
- a medical emergency warrants disclosure of information by medical personnel;
- disclosure becomes necessary for purposes of management audit, financial audits, program evaluation, or research approved by the department;
- disclosure is necessary in investigations concerning the abuse or denial of rights of mentally retarded persons; or,
- the court orders disclosure when good cause is shown in competency cases. Here the court must weigh public interest and the need for disclosure against injury to the person receiving services. The court must impose appropriate safeguards against unauthorized disclosure in determining disclosure of all or any part of the individual's record.

Access to school records by students 18 (+) years of age and by parents of younger students is authorized under the Family Education Rights and Privacy Act of 1974 (FERPA). The Act allows involved parties to inspect, copy, and challenge information contained in educational records. Sorgen (1976) states that it is of the utmost concern that adequate rules and procedures be devised to ensure confidentiality of information once it is inserted in the records. Written regulations must be promulgated in advance in order to govern access to records, to provide for identification of persons authorized to use them, to inform the individual what use will be made of the data, to review the accuracy of the data, and most importantly, to obtain consent prior to the release of any data to outside parties.[10]

Information contained in records of the mentally retarded and mentally ill residents of residential programs should include the following:[11]

1. identification data including legal status of the resident.
2. the resident's history including family data, educational background, and employment records along with physical and mental medical histories and a record of any prior institutionalization.
3. complaints or grievances listed by the resident in addition to complaints made by others about the resident.
4. a listing of the daily living skills in which the resident can engage.
5. for the mentally ill, an evaluation noting when the onset of the illness occurred, the circumstances that led to the admission, and a description of the person's intellectual, emotional, and behavioral functioning.
6. a summary of the results of all physical examinations given.
7. a copy of the resident's individualized treatment plan with any modifications made.
8. a summary of every review of the treatment plan which outlines the success and failures of the habilitation program.
9. a copy of the post-institutionalization plan designed for the resident and a description of the steps taken to implement the plan.
10. a medication history.
11. a summary of each contract a resident has with a qualified Mental Health or Retardation Professional.
12. a detailed summary of the resident's progress and/or response to the treatment plan, done on a weekly basis for mentally ill residents and on a monthly basis for mentally retarded residents.
13. a summary of the resident's work activities, done on the same time basis as specified in #12, and the effect of these work activities on the resident's progress on the treatment plan.
14. any signed orders for physical restraints, isolation, or restrictions on visitations or communication.
15. a description of any extraordinary incidents or accidents involving the residents.

16. for the mentally retarded, a summary of family visits, a summary of the resident's leaves from the institution, and a record of any seizures, illnesses, treatments for illnesses or seizures, and immunizations.

17. for the mentally ill, a summary of the findings, made by the superintendent, of the 15-day review undertaken after the person is committed to the hospital to determine if the person requires further hospitalization or institutionalization.

This information is based on specifications made by the court in Wyatt v. Stickney (1972). In this particular case, plaintiffs alleged that Partlow State School and Hospital in Tuscaloosa, Alabama was operating in an unconstitutional manner, and that the residents were denied their right to adequate habilitation. As a result, minimum medical and constitutional standards of operation were established, and a human rights committee was formed.[12]

The Developmental Disabilities Assistance and Bill of Rights Act

Under the Developmental Disabilities Assistance and Bill of Rights Act (Section 111), Congress guarantees persons with developmental disabilities the following rights:[13]

1. Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.

2. The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

3. Both the Federal Government and the states have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that:

   a. does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or

   b. does not meet the following minimum standards:

      (1) Provisions of a nourishing, well-balanced daily diet ...

(2) Provisions ... of appropriate and sufficient medical and dental services.

(3) Prohibition of the use of physical restraint on such persons unless absolutely necessary and prohibition of the use of such restraint as a punishment or as a substitute for a habilitation program.

(4) Prohibition on the excessive use of chemical restraints on such persons and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation for such persons.

(5) Permission of close relatives of such persons to visit them at reasonable hours without prior notice.

(6) Compliance with adequate fire and safety standards as may be promulgated ...

4. All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served, and ... assure that care is appropriate to the needs of the persons being served by such programs, assure that the persons admitted to facilities of such programs are persons whose needs can be met through services provided by such facilities, and assure that the facilities under such programs provide for the humane care of the residents of the facilities, are sanitary, and protect their rights ...

The Developmental Disabilities Assistance and Bill of Rights Act also establishes a habilitation plan that must meet certain requirements in order for a state to receive funds for residential programs. The following requirements should aid the service provider in setting up such a program:[14]

1. The plan shall be in writing.
2. The plan shall be developed jointly by (a) a representative or representatives of the program primarily responsible for delivering or coordinating the delivery of services to the person for whom the plan is established, (b) such person, and (c) where appropriate, such person's parents or guardian or other representative.
3. Such plan shall contain a statement of the long-term habilitation goals for the person and the intermediate habilitation objectives relating to the attainments of such goals. Such objectives shall be stated specifically and in sequence and shall be expressed in behavioral or other terms that provide measurable indices of progress. The plan

shall (a) describe how the objectives will be achieved and the barriers that might interfere with the achievement of them, (b) state an objective criteria and an evaluation procedure and schedule for determining whether such objectives and goals are being achieved, and (c) provide for a program coordinator who will be responsible for the implementation of the plan.

4. The plan shall contain a statement (in readily understandable form) of specific habilitation services to be provided, shall identify each agency which will deliver such services, shall describe the personnel (and their qualifications) necessary for the provision of such services, and shall specify the date of the initiation of each service to be provided and the anticipated duration of each service.

5. The plan shall specify the role and objectives of all parties to the implementation of the plan.

The Act also calls for an annual review of the plan by the agency primarily responsible for the delivery of services as well as revisions of individual habilitation plans.

Paramount in cases such as Wyatt v. Stickney (1972), O'Connor v. Donaldson (1975), and Pennhurst State School v. Halderman (1981) are provisions that established the rights of clients to treatment, services, and habilitation.

In O'Connor v. Donaldson the Court ruled that it is unconstitutional and a violation of rights to hold a person considered (or determined) non-dangerous in confinement. The Court went so far as to impose monetary damages against institutional officials for such a violation.[15]

To protect clients from false promises of treatment, services, and habilitation, the 5th Circuit Court of Appeals ruled in Wyatt v. Stickney that to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violate the very fundamentals of due process. This ruling is based on the quid pro quo theory which prevents the liberty of citizens from being taken away on the false pretense that a promised service will be delivered.[16] However, this argument was not upheld by the United States Supreme Court and does not necessarily apply to cases outside of the jurisdiction of the 5th Circuit Court of Appeals.

In Pennhurst State School v. Halderman the Developmental Disabilities Assistance and Bill of Rights Act came under attack. The Court ruled that the Act did not create a "directly and individually enforceable right to treatment and habilitation." But the Court said nothing to weaken the constitutional bases of such a right.[17]

In a most recent court case, Youngberg v. Romeo (1982), the Supreme Court held for the first time that mentally retarded persons in state institutions have constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment, including freedom from unreasonable bodily restraint, the right to reasonably safe conditions, and the right to minimally adequate training.[18]

Section 11 of the MRPA stipulates that every mentally retarded person has the right to receive adequate treatment and habilitative services for mental retardation suited to the person's individual needs to maximize the person's capabilities and to enhance the person's ability to cope with his environment. Such treatment and habilitation is to be administered skillfully, safely, and humanely with full respect for the dignity and integrity of the person.

Section 503 of the Vocational Rehabilitation Act of 1973

Section 503 of the Vocational Rehabilitation Act of 1973 stipulates that any contract in excess of $2,500 entered into by any Federal department or agency for the procurement of personal property and nonpersonal services (including construction) is to contain a provision requiring that federal contractors take affirmative action to employ and advance in employment qualified handicapped individuals.[19] Handicapped individuals can file discrimination suits with the

114

Department of Labor if the individual believes a contractor refuses or fails to comply with the provisions of his contract.

Section 504 of the Rehabilitation Act of 1973

Analogous to the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 has become the major tool used by handicapped individuals to fight against discrimination practices. Heralded as the nation's first law to protect the civil rights of the handicapped, the Act provides that:[20]

> No otherwise qualified individual ... shall solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In general, Section 504 prohibits discrimination against handicapped persons in areas of employment, program accessibility, student programs, student activities and student services. Subparagraph 84.4 (b) (1), states that preschool, elementary, secondary, and adult education recipients of Federal financial assistance, in providing any aid, benefit, or service either directly or through any contractual, licensing or other arrangement shall not:[21]

1. deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;
2. afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
3. provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;
4. provide different or separate aid, benefits, or service to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefit, or services that are as effective as those provided to others;
5. aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the institution's program;
6. deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

7. otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving aid, benefit, or service.

The term "qualified handicapped person" as defined under Section 504 means:[22]

1. with respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question; and

2. with respect to public preschool, elementary, secondary or adult educational services, a handicapped person:

    a. who is of an age during which nonhandicapped persons are provided such services;

    b. who is of any age during which it is mandatory under state law to provide such services to handicapped persons; or

    c. to whom a state is required to provide a free appropriate public education under Section 612 of the Education of the Handicapped Act. Section 612 ... required states to make available a free appropriate public education for all handicapped children in the state between the ages of three and eighteen not later than September 1, 1978, and for all handicapped children between three and twenty-one not later than September 1, 1980.

This section has described in general terms the legal rights afforded all citizens. These various rights for the most part are taken for granted by the average citizen; but for those persons with developmental disabilities these rights attribute to and are a necessary part of independent living. The legal authorities described here protect and maintain the rights of the handicapped. They provide the legal basis through which the handicapped can fight claims of discrimination and obtain their goal to live as normal and independent a life as possible.

AC MRDD

The Accreditation Council for Mentally Retarded and Other Developmentally Disabled Persons (AC MRDD) was established in 1969 to develop and promote standards for assessing residential programs. In developing these standards, the Council had strong ideological ties with theories of normalization, the developmental model, individualization, and an interdisciplinary team approach to assessing and establishing services for persons with developmental disabilities. The use of AC MRDD's standards and surveys is increasing, and one-third of state directors are currently using them for both licensing purposes and evaluating services.

Components

The following information is a breadkown of the AC MRDD standards as defined by the Council:

Section 1:

Individual Program Planning and Implementation: the provision of systematic and organized services and interventions that are designed to enhance the lives of developmentally disabled individuals. These services and interventions must be provided in accordance with a definite plan based on a determination of the individual's developmental status and needs.[23]

1.1 The Interdisciplinary Process

1.2 Evaluation and Assessment

1.3 The Individual Program Plan

1.4 Individual Program Implementation

    1.4.1 Physical Development and Health
    1.4.2 Mobility
    1.4.3 Habilitation, Education, and Training
    1.4.4 Work and Employment
    1.4.5 Recreation and Leisure
    1.4.6 Behavior Management

1.5 Individual Program Coordination

1.6 Programming Records

Section 2:

Alternative Living Arrangements: places of residence that substitute for the individual's own home or for the home of the individual's family, and that afford living experiences appropriate to the individual's functioning level.[24]

2.1 Attention to Normalization and Use of Least Restrictive Alternatives

2.2 Homemaker and Sitter/Companion Services

2.3 Temporary-Assistance Living Arrangements

2.4 Surrogate Family Services

2.5 Congregate Living Services

  2.5.1 The Congregate Living Environment
  2.5.2 Staffing and Staff Responsibilities

Section 3:

Achieving and Protecting Rights: refers to the fact that because of a developmental disability, individuals are frequently denied their human and civil rights. This occurs not only in the course of their everyday lives, but also in the course of receiving needed services. Consequently, special attention and effort are required to assure that these human and civil rights are exercised and protected.[25]

3.1 Attention to Individual Rights and Responsibilities

3.2 Advocacy

  3.2.1 Self-Representation
  3.2.2 Personal Advocacy
  3.2.3 Agency Advocacy

3.3 Protective Services

Section 4:

Individual Program Support: those agency activities and resources that must be provided for and directed to the support of individual program planning and implementation.[26]

4.1 Agency, Philosophy, Policies, and Procedures

4.2 Case Finding

4.3 Entry, Admission, and Discharge

4.4 Follow Along

4.5 Family-Related Services

    4.5.1 Home Training Services
    4.5.2 Family Education Services

4.6 Professional Services

4.7 Staffing and Staff Qualifications

4.8 Staff Training

4.9 Volunteer Services

4.10 Government and Management

    4.10.1 Governing Body and Administration
    4.10.2 Fiscal Affairs
    4.10.3 Personnel Policies
    4.10.4 Documentation

4.11 Program Evaluation

4.12 Provision and Maintenance of Facilities and Equipment

Section 5:

Safety and Sanitation: the agency's premises, in addition to being as normalized as possible, must be safe and sanitary. Consequently, the agency must comply with the fire, sanitation, health and environmental safety codes and regulations of the state or local authorities that have primary jurisdiction over these matters.[27]

Section 6:

Research and Research Utilization: a systematic and detailed attempt to discover or confirm facts relating to the problems associated with developmental disabilities. Research utilization includes the dissemination of research findings and the use of such findings to improve services for developmentally disabled individuals.[28]

Section 7:

The Agency in the Service Delivery System: the service delivery system is the network of specialized and generic service components that is directed toward meeting the general and extraordinary needs of the developmentally disabled individuals in the population served.[29]

7.1 Coordination

7.2 Resource Information and Data Documentation Services

7.3 Community Education and Involvement

7.4 Prevention

7.5 Manpower Development

Organization

The Council is comprised of a core of organizations and professionals governed by a Board of Directors. The most current organizations include:

The American Association on Mental Deficiency

American Occupational Therapy Association

American Psychological Association

Association for Retarded Citizens

Council for Exceptional Children

Epilepsy Foundation of America

National Association of Private Residential Facilities for the Mentally Retarded

National Association of Social Workers

National Society for Autistic Children

United Cerebral Palsy Association

The governing board is composed of two representatives from each of the various organizations.

The Council maintains advisory committees made up of professionals and technicians concerned with administration, architecture, business management, denistry, dietetics and nutrition, education, library services, medicine, nursing, pharmacy, physical and occupational therapies, psychology, pathology and audiology, vocational rehabilitation and volunteer services. Their input is of great value to the Council in developing the standards.

The standards established by the Council are not static and come under constant review and revisions in order to keep in touch with current knowledge and practice in the field. The major focus of the Council is to maintain a systematic evaluation of existing residential facilities and programs in comparison to nationally recognized standards. The evaluation is conducted by agencies outside the programs and is strictly voluntary on the part of the facility.

Eligibility Requirements

In order to be eligible for accreditation, a residential program must be in operation under the same ownership or control for at least one year so that a performance record is available for examination during the survey. Other eligibility requirements include:[30]

- the program provides services to the developmentally disabled and their families.

- these services are part of a process of developing, implementing, and periodically re-evaluating an individual program plan for each individual served.

121

- the organization is, or is seeking to become, part of a service delivery system offering services that meet the needs of all developmentally disabled individuals within the community that it serves.

- the organization operates without regard to race, color or national origin and in accordance with clearly defined administrative responsibilities.

- it possesses a current license to operate, if such is required by the state in which it is located.

Steps in Applying for Accreditation

The accreditation process sets the standards for services and determines the degree to which the standards are met. The steps involved in the accreditation process are generally straight-forward and thorough.[31]

1. The facility should become familiar with the standards. The Council offers one- to two-day workshops designed to aid the service provider in better understanding the standards and their applications. On-site workshops are provided to offer more specific assessments as to whether an agency's staff understands the standards as demonstrated by their attempt to implement them.

2. A self-survey should be conducted to determine whether or not the facility is in compliance with the standards.

3. Trained AC MRDD staff or consultants will then conduct an on-site survey. Prior to such a survey, the agency must complete and return to the Council an application for Survey, a Survey Questionnaire, a Statement of Compliance with Safety and Other Requirements for each of its buildings, and any other document required by the Council.

4. A "program audit" is carried out on a sample of residents representing various ages and disabilities. The audit is designed to assess compliance with those standards most directly related to the delivery of adequate services. The surveyor's assessments are based upon observations of the activities of each resident in the sample, discussions with the resident and

with the staff responsible for implementing his or her IPP, and careful review of relevant records. Also, an agency's responses to questions answered in a Survey Questionnaire are taken into consideration.

5. The surveyors conduct a Public Information Interview with parents, advocates, representatives of other agencies, and concerned citizens in order to obtain candid appraisal of the facility's strengths and weaknesses. In order to inform those interested individuals who feel they have pertinent information about the agency's conformance to standards, the agency must post a notice in a public place on its premises which announces the dates of the survey and the date and time of the Public Information Interview. The agency is not, however, required to inform the mass media. The interviews last, at the most, two hours. All findings that result from the interviews are included in the final Survey Report upon completion of the survey. All information obtained through the survey process and through public interviews (i.e., contained in the Survey Report) is confidential between the Council and the agency.

Finally, the AC MRDD staff members review their findings with the facility's staff in a Summation Conference. The results of the survey are compared with the facility's self-assessment, and evidence of areas in which there was less than full compliance with the standards is cited and interpreted. Following the survey, the facility receives a written report (i.e., Survey Report) which summarizes the findings, presents recommendations for improvement, and conveys the accreditation decision.

A facility will receive accreditation when it meets a fixed percentage of standards as predetermined by the Council's Board of Directors. Accreditation is only applicable for one to two years. If accreditation is not granted or is revoked, the agency can apply for a re-survey six months following the Council's decision.

The series of steps involved in the decision and appeals processes are outlined below:

1. A summation conference is held at the completion of the survey with representatives of the agency and the surveyors in attendance. Surveyors compare their findings with the agency's self-assessment of compliance and discuss the reasons for those assessments that differ from the agency's self-assessments.

2. Those assessments that have been confirmed by the surveyors as not being in full-compliance with the standards are written up in the Survey Report. It is from a review of this Report and any other relevant information that the Accreditation Committee (i.e., composed of members of the Board of Directors) makes its final decision on accreditation. The Council defers action for 12 months to give the agency time to make the necessary changes. At the end of 12 months, the agency must apply for a re-survey to determine its compliance to those standards in question.

3. If accreditaion is denied or revoked, the agency is granted an interview with a representative of the Accreditation Council for the purpose of debating the surveyor's findings in an attempt to demonstrate that their facility is in full compliance with the standards. The agency must request such an interview within 20 days of receiving notification of deficiencies in compliance with the standards. If not, the Council's decision becomes final.

4. If a decision is made to deny or revoke accreditation at the interview, the agency can request an appeal and schedule a hearing before an appeals Hearing Panel. The Panel is composed of three impartial individuals who are not members of the Board, but who are chosen by the Board. Again, the agency has 20 days to request such a hearing before the Council's decision becomes final.

5. At the hearing, the agency can be represented by counsel, make oral presentations, offer testimony, and examine any surveyor who participated in the original on-site survey. The agency must notify a surveyor 15 days in advance of the hearing and must submit a statement of their position.

6. Following the hearing, the Panel submits its decision on accreditation to the Board of Directors. If the Panel's decision is to deny or revoke accreditation, the agency can appeal the decision; the Board will then review any written responses or comments, the Survey Report, and/or any material or information that was considered by the Appeals Hearing Panel. A final decision is made on whether or not to accredit the agency.

7. If the agency challenges the reasonableness of any standard that it has not found to be in full-compliance with, the agency can request a hearing before the Standards Committee of the Accreditation Council. Written requests from the agency must be made 20 days following the mailing to the agency of notification of the accreditation decision. The Standards Committee reports its judgement of the reasonableness of the standard(s) in question to the Board who may or may not amend such a standard(s). If an amendment is made in favor of the agency, the agency will be re-surveyed at no cost to themselves.

McCann and McCann (1980) list several advantages of the AC MRDD survey:[32]

1. A facility that has undergone the AC MRDD survey process and has received accreditation can be justly proud; it is one of a select group of programs in the country that has demonstrated its ability to provide high caliber services.

2. Regardless of whether a facility is actually accredited, it should profit greatly from the self-survey. This activity provides the staff with an opportunity to assess their efforts carefully against a detailed set of

nationally recognized criteria. In the process, staff members are likely to identify areas in which they can take specific steps to upgrade services.

3. There are substantial educational and consultative benefits inherent in obtaining detailed feedback from an independent team of qualified surveyors.

4. Many administrators of residential programs have found that participation in an AC MRDD survey provides their staff with a strong motivation to take positive action to upgrade their services.

5. By participating, a facility demonstrates to the public that it is accountable to them. This can generate community and legislative support and can also show a genuine commitment for excellence.

Two of the most negative aspects of the survey which were cited by state directors are the costs of fees and the costs in staff time required for the accreditation process. How long the survey takes depends on the facility's size and the complexity of its programs. The usual amount of time is two to four days and requires up to three surveyors. The facility is responsible for one half of the survey fee; the remainder of the fee is picked up by a grant from the U.S. Department of Health and Human Services Administration on Developmental Disabilities.

ICF/MR

Federal standards for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) pertain to those facilities that receive federal Medicaid funds for health or habilitative services. As mentioned in Chapter II, the ICF concept originated as a level of care for those individuals who did not require 24-hour, intense nursing care, but did require more care and services than room and board. Facilities receiving ICF/MR reimbursement must rigorously conform to federal, state and local laws, codes, and regulations which relate to health and safety standards. These standards originated from the original AC MRDD standards of 1971. According to McCann and McCann (1980), the ICF/MR certification process has been subject to criticism for the following reasons:[33]

1. Because they are incorporated in federal regulations, the ICF/MR standards are "frozen" in the language of the 1971 Accreditation Council standards from which they are taken. In contrast, the Council's standards have undergone extensive revision and updating in order to reflect the current "state of the art."

2. The federal standards were taken from AC MRDD standards that were intended to be applied to facilities according to the needs of the residents being served. The application of every ICF/MR standard to every facility has often resulted in a rigid model of service which is contrary to the intent and practice of AC MRDD.

3. ICF/MR surveys are frequently conducted by persons who lack training and experience in the developmental disabilities field. Their inability to make meaningful, programmatic judgements has, in a number of instances, caused these surveyors to focus on quantifiable requirements (e.g., square footage and staff ratios) rather than program quality. However, ICF/MR

regulations require that at least one member of the team must have knowledge of the problems and needs of the mentally retarded.

4. Typically, ICF/MR surveyors are state employees whose role is to evaluate the programs of other state agencies in order to determine their eligibility to receive substantial amounts of federal Medicaid monies. The built-in conflict of interest is clear. In fact, some surveyors have complained that they are under pressure to certify facilities that they inspect and that their failure to do so has sometimes been overruled by the higher ups.

Rather than repeat ICF/MR information contained in Chapter II, this section will acquaint the service provider with examples of ICF/MR regulations and survey procedures, typical services provided under ICF/MR programs, and ICF/MR criteria used to determine the level of care required.

ICF/MR standards are enforced by designated state agencies. A survey team from the agency certifies a facility upon compliance with quality assurance and physical plant standards. The survey team reviews three areas including services, staff, and facility. Services and staffing standards are combined under quality assurance mechanisms for reviewing purposes. These mechanisms must describe and define:[34]

1. services.
2. the procedures for prescribing and delivering services.
3. the qualifications and responsibilities of direct care and supervisory staff.
4. The records required for services delivered and for individuals receiving the services.

Another important component contained in the ICF/MR rules and regulations is the Life Safety Code. The Code, developed by the National Fire

128

Protection Association, applies to the physical plant of the ICF/MR. The Code is amended every three years and contains requirements for:[35]

1. bedroom space for single and multiple occupancy.
2. control of hot water temperature.
3. bathroom sizes and fixture descriptions.
4. kitchen and laundry facilities.
5. stairways and doorways.
6. other physical aspects.

The facility must have an approved fire alarm system installed through a service-maintenance agreement with a state certified agency. The same agency that installs the fire alarm system must also inspect the system annually. Though the following list of regulations is far from complete, fire protection is maintained through regulatory standards such as these:

1. There must be two means of exit from bedrooms, living rooms, and dining rooms with at least one door in each room to provide an exit to the outside at street level.

2. Each bedroom must have a window that opens easily from the inside. The opening must measure at least 16" x 25."

3. Interior finishes on walls, floors, and ceiling are classified by levels of hazards (i.e., Class "A", "B", "C"). These classifications are flame-spread index ratings of 200 or less. ICF regulations strongly suggest that ceilings be Class "A" (25 or less) and carpeting be Class "B" (75 or less).

4. Stairways must comply to minimum requirements of width (36" minimum), risers (8" maximum), and treads (9" minimum).

5. Monthly fire drills are strongly recommended, though the standard calls only for quarterly drills per shift. These fire drills must be recorded as they are one of the major documents reviewed by the survey team.

The ICF/MR rules and regulations are divided into interpretive guidelines and survey procedures, and the surveyor benefits from the guidelines and procedures which serve as tools for certification, interpretation of the regulations, and suggestions on how to survey a facility. A few guidelines are recommendations and not final regulations, and these particular guidelines are termed either "it is recommended" or "at least" (i.e., "the linen supply is at least 3 times the number of occupied beds," CFR 249.12.1.6ii).

The following charts are examples of standards, interpretive guidelines, and survey procedures as they appear in the Final Interpretative Guidelines for the Application of Regulations for Institutions for the Mentally Retarded or Persons with Related Conditions (CFR 249.13.a.1.ii(B) and CFR 249.13.f.1.i and ii).[36]

I

STANDARD	INTERPRETIVE GUIDELINES	SURVEYOR PROCEDURES
249.13(a)(ii)(B) (B) Ensure that each resident admitted to the facility:		
(1) Is fully informed of his rights and responsibilities as a resident and of all rules and regulations governing resident conduct and responsibilities. Such information must be provided prior to or at the time of admission or, in the case of residents already in the facility, upon the facility's adoption or amendment of resident rights policies, and its receipt must be acknowledged by the resident in writing; and in the case of a mentally retarded individual, witnessed by a third person.	(1) It is important that residents understand what they can expect from the facility and its staff, and what is expected from them. The facility, therefore, has clearly defined policies and procedures for communicating these expectations...not more than two weeks before or 5 days after admission. Such communication is in writing...and interpreted verbally...	(1) Surveyor reviews written materials that inform residents of their rights and responsibilities, and verifies that they are prominently posted.
	(2) Resident's rights and responsibilities are presented in language understandable to the resident...Residents should be encouraged to ask questions about their rights and responsibilities, and these questions should be answered.	(2) Procedures for verbally informing residents are reviewed for content and identification of the facility staff member(s) assigned this function. Such staff are interviewed to verify their knowledge of resident's rights and their ability to communicate it in language understandable to residents.
	(3) A statement is signed by the resident, indicating an understanding of these rights and responsibilities, and is maintained in the record. Facility policies should indicate that such a statement is signed by the resident no later than 5 days after admission and that a copy...is given to the resident or guardian.	(3) A number of resident's records are checked to verify: a. That residents have signed a form indicating an understanding of their rights and responsibilities... b. When a resident is unable to understand this information, the resident's guardian or responsible relative has been informed.
		(4) A sample of residents are interviewed to verify their understanding of their rights.

STANDARD	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
249.13(f)(1)(i) and (ii)		
(i) There shall be a written staff organization plan and detailed, written procedures, which are clearly communicated to, and periodically reviewed with, staff for meeting all potential emergencies and disasters pertinent to the area, such as fire, severe weather, and missing persons. The plans and procedures shall be posted at suitable locations throughout the facility.	(i) The disaster plan is developed in conjunction with medical resources in the community and coordination with other community disaster preparedness activities. The plan includes procedures for prompt transfer of residents and records to an appropriate facility; fire/emergency drills, in accordance with Life Safety Code; arrangements by community resources in event of disaster.	(i) The surveyor verifies that procedures or information are posted for: Evacuation routes; assignment of personnel; location and instructions for use of equipment; and frequency of drills. Check plan for coverage of internal as well as external disasters. Check plan for review program and determine whether there is an ongoing training program. Talk with staff to verify awareness of plan and assignments.
(ii) Evacuation drills shall be held at least quarterly, for each shift of facility personnel and under varied conditions in order to: (A) Insure that all personnel shifts are trained to perform assigned tasks; (B) Insure that all personnel on all shifts are familiar with the use of the firefighting equipment in the facility; and, (C) Evaluate the effectiveness of disaster plans and procedures.	(ii) Written records of fire drills and disaster drills give in detail: (1) the plans for assignment of personnel to specific tasks and responsibilities; (2) instructions relating to the use of alarm systems and signals; (3) information concerning methods of fire containment; (4) systems for notification of appropriate persons; (5) information concerning the location of firefighting equipment; (6) specification of evacuation routes and procedures.	(ii) Surveyor examines the written record of fire drills and disaster drills to assure that procedures outlined in the organization plan were followed.

The survey process tends to be hectic and often a tense period of time for many ICF/MR service providers. The survey team consists of approximately 3 qualified professionals (i.e., a nurse, nutritionist, and social worker), each focusing on his/her own area of specialty during the survey. As one service provider observed, the survey team begins their first day's visit asking for all relevant documents, "and then some." After reviewing the documents, they generally separate and go on to specific areas of their own expertise.

The survey process is enumerated below for easy reference:

1. The facility's staff are to complete a self-evaluation, paying particular attention to those areas designated as deficiency problems from the previous facility survey.

2. The survey team arrives on a designated day for a three- to four-day examination of the facility.

3. Prior to the visit, the team sends the service provider a two to three-page report enumerating the areas they want to focus on (including all relevant documents).

Note: Throughout the survey, the team discusses with the staff those problems that have occured over the past year. The staff must also be prepared to answer an undetermined number of questions concerning the program and the physical plant. If it is determined by the survey team that certain areas of the program are not being met, an outside consultant is sent in to help pinpoint problem areas and reorganize the most urgent program needs.

4. Upon completion of the survey, the team meets with the administrators to discuss their conclusions which have been written up in a Summation Report. At this time, the staff receives a Deficiency Plan which enumerates those areas that do not comply with the regulatory standards. For each deficiency area, the service provider must prepare a Plan of Correction that addresses each area

of deficiency. When these areas have been corrected, they are dated and cross-referenced to the appropriate deficiency in a final report. The facility is usually given at least 30 days to correct any deficiencies, but the time period can vary depending on the program and the nature of the deficiencies.

There are two classifications of deficiencies:

a. Deficiencies that are required to be met by the ICF/MR rules and regulations.

b. Recommendations by the survey team that are not required to be met, but can lead to deficiencies at subsequent surveys. For instance, one ICF/MR facility (located near a busy street) had a fence surrounding the complex. The survey team felt the fence made the facility look "too institutional" and recommended that it be taken down.

When deficiencies are noted by the survey team, the facility is put on a Vendor-Hold. This simply means that Medicaid payments are discontinued until the facility corrects the deficiencies in order to comply with ICF standards. The most extreme action that can be taken against a facility is a complete cancellation of the ICF/MR program as contractually agreed upon. In Texas, the Department of Human Resources has an Automatic Cancellation Clause in their contracts with vendors.

5. Finally, the survey team re-visits the facility to check only those areas which had been designated as deficiencies. Upon completion of the second visit, the team meets with the staff in a Wrap-Up Session to discuss final decisions (i.e., whether or not to drop the Vendor-Hold, give the facility compliance status, cancel the program, etc.). Provider agreement and certification of the facility is recommended by the survey team when it is determined that all deficiencies have been corrected and the facility is in compliance with ICF standard rules and regulations.

The Life Safety Code is another important area that the team closely investigates. The service provider must remember that the National Fire Safety Code sections are extremely important for certification purposes and strict adherence to the rules and regulations is necessary. Also, a facility must have a program in operation at least 30 to 90 days prior to applying for certification.

As can be seen from the survey process, the team of surveyors is very thorough in its approach to making sure the ICF programs are followed "to the letter of the law," and particular attention is given to documentation to determine that records and reports are accurate and technically correct. The team can be very fastidious about various aspects of the physical plant (even down to the smallest detail). Such a thorough investigation serves to ensure a safe and secure environment for the residents.

ICF/MR Services

Professional and special service needs of residents of ICF/MR's are determined by interdisciplinary teams made up of representatives from each service area under contract with the facility. The team conducts an evaluation of each individual and his/her active treatment plan prior to admission to the program; re-evaluation is conducted every month thereafter.

The active treatment plan is an important component of ICF regulations since Congress has stipulated that such a plan must exist in order for a resident to receive Medicaid support. The active treatment plan is devised in such a manner as to develop the resident's fullest functional capacity and requires (CFR 249.10.d.l.v):[37]

A. Regular participation, in accordance with an individual plan of care in professionally developed and supervised activities, experiences, or therapies.

B. An individual "plan of care" which is a written plan that sets forth measurable goals or behaviorally stated objectives and prescribes an integrated program of individually designed activities, experiences or therapies necessary to achieve such goals or objectives. The overall objective of the plan is to attain or to maintain the optimal physical, intellectual, social, or vocational functioning of which the individual is presently or potentially capable.

C. An interdisciplinary, professional evaluation consisting of complete medical, social and psychological diagnosis and evaluation, and an evaluation of the individual's need for institutional care, prior to but not to exceed 3 months before admission to the institution or, in the case of individuals who make application while in such institution, before requesting payment under the plan...The evaluation is conducted by a physician, a social worker and other professionals.

D. Medical, social, and psychological re-evaluation at least annually by the staff involved in carrying out the resident's individual plan of care, including review of the individual's progress toward meeting the plan objectives, the appropriateness of the individual plan of care, assessment of continuing need for institutional care, and consideration of alternate methods of care.

E. An individual post-institutionalization plan (as part of the individual plan of care) developed prior to discharge by a qualified mental retardation professional and other appropriate professionals, including provisions for appropriate services, protective supervision, and other follow-up services in the resident's new environment.

Specific services included under the ICF program include: dental services, training and habilitation, food and nutrition services, medical services, nursing services, pharmacy services, physical and occupational therapy, recreational services, psychological services, social services, speech pathology and audiology services, laundry services, and resident-living services. Each service area has standard rules and regulations (where applicable) for staff and staff duties including procedures, record keeping, facility maintenance, and special considerations (i.e., emergency cases). For example, medical services are stipulated as being available for each resident seven days a week on a 24-hour basis. The facility's health service nurse is responsible for following and recording preventive measures, treatments, and medication as prescribed by the staff physician. Residents are given an annual examination requiring vision and hearing check-ups, laboratory tests (if necessary, immunizations and tuberculosis tests, and reports on communicable diseases and infections.) Thorough medical records must be kept on every resident. Adequate space, facilities, and equipment must be provided to meet the residents' medical needs. Finally, under special considerations, if an individual's immunization record is needed and cannot be obtained, the physician should be contacted to certify that the individual is free of communicable diseases. Also, if the physician is unavailable during an emergency, the individual(s) should be taken to a hospital emergency room.

I.Q. and Adaptive Behavior

Before any details of ICF levels of care are discussed, it might be helpful to acquaint the service provider with the various levels of mental retardation. To diagnose an individual as being "mentally retarded," that individual's intellectual functioning (or measured intelligence) is not the only consideration; the individual's ability to adapt in his environment is another important component. Both intellectual functioning and adaptive behavior are broken down into degrees of impairment, and the individual who is classified as mentally retarded must manifest deficiencies in both these areas. The degrees of impairment are divided into four categories: Mild, Moderate, Severe, and Profound.

The two tests most widely used to measure intelligence are the Stanford-Binet and the Wechsler Scales. Though IQ alone is not a good indicator of whether or not the individual can adapt to his environment, the IQ values that correspond with the four levels of mental retardation are presented in the following chart:[38]

LEVELS	OBTAINED INTELLIGENCE QUOTIENT	
	Stanford-Binet (s.d. 16)	Wechsler Scales (s.d. 15)
MILD	67-52	69-55
MODERATE	51-36	54-40
SEVERE	35-20	
PROFOUND	19 and below	

The classification of the obtained scores is based upon the assumption that the abilities measured by intelligence tests are distributed in the general population according to the normal probability curve. The separation into four levels of mental retardation is scaled in terms of standard deviation (s.d.) units which describe the distribution of scores in the general population that would be expected for a particular test if the abilities measured by the test are normally distributed.

Unfortunately, there has been a tendency to look primarily at a person's intelligence scores when diagnosing the individual as mentally retarded. This occurs mainly because the criteria for IQ scores is quantitative while the criteria for adaptive behavior is qualitative and, as a result, more difficult to measure. Two of the scales most widely used to measure adaptive behavior are the Vineland Social Maturity Scale and the AAMD Adaptive Behavior Scale.

Since an important test of independent living is how well the individual can adapt to his environment, the focus for service providers should be on the client's level of adaptive behavior first, and IQ should be used only as a correlary measure. Looking at the client from a developmental perspective, the AAMD has developed eight dimensions of adaptive behaviors:

1. Sensorimotor skills
2. Communication skills
3. Self-help skills
4. Socialization (ability to interact with others)
5. Application of basic academic skills in daily life activities
6. Application of appropriate reasoning and judgement in mastery of the environment
7. Social skills (participation in group activities and interpersonal relationships)
8. Vocational and social responsibilities and performance

The AAMD developed a table that illustrates the highest levels of independent functioning, physical abilities, communication skills, social skills, economic activity, occupation, and self-direction at given ages of development. The table is presented here to help illustrate the necessity of using levels of adaptive behavior and functioning skills as criteria for entering clients into independent living programs. The table is extrapolated from the AAMD Manual on Terminology and Classification in Mental Retardation.[39]

AGE AND LEVEL INDICATED	ILLUSTRATIONS OF HIGHEST LEVEL OF ADAPTIVE BEHAVIOR FUNCTIONING
Age 2 years and above: Profound	Independent functioning: Drinks from cup with help; cooperates by opening mouth for feeding. Physical: Sits unsupported or pulls self upright momentarily; reaches for objects; has good thumb-finger grasp; manipulates objects (e.g., plays with shoes or feet). Communication: Imitates sounds, laughs or smiles back (Says "Dada, buh-buh" responsibly); no effective speech; may communicate in sounds and/or gestures; responds to gestures and/or signs. Social: Indicates knowing familiar persons and interacts nonverbally with them.
Age 3 years: Severe Age 6 years and above: Profound	Independent functioning: Attempts finger feeding; "cooperates" with dressing, bathing, and with toilet training; may remove clothing (e.g., socks) but not as an act of undressing as for bath or bed. Physical: Stands alone or may walk unsteadily or with help; coordinates eye-hand movements. Communication: One or two words (e.g., Mama, ball) but predominantly vocalization. Social: May respond to others in predictable fashion; communicates needs by gestures and noises or pointing; plays "patty-cake" or plays imitatively with little interaction; or occupies self with toys for a few minutes.
Age 3 years: Moderate Age 6 years: Severe Age 9 years: Profound	Independent functioning: Tries to feed self with spoon; considerable spilling; removes socks, pants; "cooperates" in bathing; may indicate wet pants; "cooperates" at toilet. Physical: Walks alone steadily; can pass ball or objects to others; may run and climb steps with help. Communication: May use four to six words; may communicate many needs with gestures (e.g., pointing).

	Social: Plays with others for short periods, often as parallel play or under direction; recognizes others and may show preference for some persons over others.
Age 3 years: Mild Age 6 years: Moderate Age 9 years: Severe Age 12 years and above: Profound	Independent functioning: Feeds self with spoon (cereals, soft foods) with considerable spilling or messiness; drinks unassisted; can pull off clothing and put on some (socks, underclothes, boxer pants, dress); tries to help with bath or hand washing but still needs considerable help; indicates toilet accident and may indicate toilet need. Physical: May climb up and down stairs but not alternating feet; may run and jump; may balance briefly on one foot; can pass ball to others; transfers objects; may do simple formboard puzzles without aid. Communication: May speak in two or three word sentences (Daddy go work); name simple common objects (boy, car, ice cream, hat); understands simple directions (put the shoe on your foot, sit here, get your coat); knows people by name. If non-verbal, may use many gestures to convey needs or other information. Social: May interact with others in simple play activities, usually with only one or two others unless guided into group activity; has preference for some persons over others.
Age 6 years: Mild Age 9 years: Moderate Age 12 years and above: Severe Age 15 years and above: Profound	Independent functioning: Feeds self with spoon or fork, may spill some; puts on clothing but may need help with small buttons and jacket zippers; tries to bathe self but needs help; can wash and dry hands but not very efficiently; partially toilet trained but may have accidents. Physical: May hop or skip; may climb steps with alternating feet; rides tricycle (or bicycle over 8 years); may climb trees or jungle gym; play dance games; may throw ball and hit target. Communication: May have speaking vocabulary of over 300 words and use grammatically correct sentences. If non-verbal, may use many gestures to communicate needs. Understands simple verbal communications including directions and questions ("Put it on the shelf." "Where do you live?"); (Some speech may be indistinct sometimes). May recognize advertising words and signs (Ice Cream, STOP, EXIT, MEN, LADIES). Relates experiences in simple language. Social: Participates in group activities and simple group games; interacts with others in simple play ("Store," "House,") and expressive activities (art and dance).
Age 9 years: Mild Age 12 years: Moderate Age 15 years	Independent functioning: Feeds self adequately with spoon and fork; can butter bread; (needs help with cutting meat); can put on clothes and can button and zipper clothes; may tie shoes; bathes self with supervision; is toilet trained; washes face and hands without help.

and older: Severe	Physical: Can run, skip, hop, dance; uses skates or sled or jump rope; can climb up or down stairs alternating feet; can throw ball to hit target. Communication: May communicate in complex sentences; speech is generally clear and distinct; understands complex verbal communication including words such as "Because" and "But." Recognizes signs, words, but does not read with comprehension prose materials. Social: May participate in group activities spontaneously; may engage in simple choices which are maintained over weeks or months. Economic Activity: May be sent on simple errands and make simple purchases with a note; realizes money has value but does not know how to use it (except for coin machines). Occupation: May prepare simple foods (sandwiches); can help with simple household tasks (bedmaking, sweeping, vacuuming); can set and clear table. Self Direction: May ask if there is "work" for him to do; may pay attention to task for 10 minutes or more; makes efforts to be dependable and carry out responsibility.
Age 12 years: Mild Age 15 years and above: Moderate	Independent Functioning: Feeds, bathes, dresses self; may select daily clothing; may prepare easy foods (peanut butter sandwiches) for self or others; combs/brushes hair; may shampoo and roll up hair; may wash and/or iron and store own clothes. Physical: Good body control; good gross and fine motor coordination. Communication: May carry on simple conversation; uses complex sentences. Recognizes words, may read sentences, ads, signs, and simple prose material with some comprehension.
Age 12 years: Mild Age 15 years and above: Moderate	Social: May interact cooperatively and/or competitively with others. Economic Activity: May be sent on shopping errand for several items without notes; makes minor purchases; adds coins to dollar with fair accuracy. Occupation: May do simple routine household chores (dusting, garbage, dishwashing; prepare simple foods which require mixing). Self Direction: May initiate most of own activities; attend to task 15-20 minutes (or more); may be conscientious in assuming much responsibility.
Age 15 years and adult: Mild Note: Individuals who routinely perform at higher levels of	Independent Functioning: Exercises care for personal grooming, feeding, bathing, toilet, may need health or personal care reminders, may need help in selection of purchase of clothing. Physical: goes about hometown (local neighborhood in city, campus at institutions) with ease, but cannot go to other towns alone without aid; can use bicycle, skis, ice skates, trampoline or other equipment requiring good coordination.

competence in adaptive behavior than illustrated in this pattern should not be considered as deficient in adaptive behavior. Since by definition an individual is not retarded unless he shows significant deficit in both measured intelligence and in adaptive behavior, those individuals who function at higher levels than illustrated here cannot be considered to be retarded.

Communication: Communicate complex verbal concepts and understands them; carries on everyday conversation, but cannot discuss abstract or philosophical concepts; uses telephone and communicates in writing for simple letter writing or orders but does not write about abstractions or important current events.
Social: Interacts cooperatively or competitively with others and initiates some group activities, primarily for social or recreational purposes; may belong to a local recreation group or church group, but not to civic organizations or groups of skilled persons (e.g., photography club, great books club, or kennel club); enjoys recreation (e.g., bowling, dancing, TV, checkers, but either does not enjoy or is not competent at tennis, sailing, bridge, piano, or other hobbies requiring rapid or involved or complex planning and implementation.
Economic Activity: Can be sent or go to several shops to make purchases (without a note to shopkeepers) to purchase several items; can make change correctly, but does not use banking facilities; may earn living but has difficulty handling money without guidance.
Occupation: Can cook simple foods, prepare simple meals; can perform everyday household tasks (cleaning, dusting, dishes, laundry); as adult can engage in semi-skilled or simple skilled jobs.
Self Direction: Initiates most of own activity; will pay attention to task for at least 15-20 minutes; conscientious about work and assumes much responsibility but needs guidance for tasks with responsibility for major tasks (health care, care of others, complicated occupational activity).

ICF/MR Criteria for Level of Care Required

As mentioned earlier, there are three ICF levels of care, and each level must adhere to strict criteria in admitting and providing services to residents. The service provider may find the following information useful when deciding which facility will best serve his clients.

Level I

No more than 15 beds are permitted, as the number of residents cannot exceed that capacity, nor exceed the facility's provision for adequate programming. Individuals who reside in this ICF level must be ambulatory, must be able to evacuate the facility in case of an emergency, must be under active treatment for rehabilitation, and they require only a minimal amount of care and supervision on a daily basis. These individuals are educable or trainable because they are capable of learning simple manual services or trades.

According to information compiled by the Texas Department of Public Welfare (1975), ICF Level I residents' functional levels include the following:[40]

1. fair social awareness;
2. good motor development;
3. probability of experiencing and profiting from self-help guidance;
4. minimal retardation in sensorimotor areas;
5. capability of social and vocational development to an adequate level with proper education and training;
6. a need for supervision and guidance under serious social or economic stress.

Level V

Level V facilities are for moderately retarded individuals who do not require 24-hour nursing care, but do require more care and supervision than the Level I (15 beds or less), and for whom the best developmental progress can be achieved in an institutional setting. These individuals can be ambulatory, or mobile non-ambulatory, and they, too, are considered trainable.

According to the DPW, the following functional levels apply to residents who reside in this particular ICF level:

1. The individual's condition is such that more services are needed at any given time (including licensed nursing, observation and evaluation).

2. The individual has fair motor development but poor muscle coordination.

3. The individual can develop limited social skills.

4. Communication skills are limited; the individual speaks in simple phrases, learns to write his/her own name, can read simple sentences, and has a short attention span and variable concentration.

5. The individual is generally slower to profit from training in self-help skills and requires much supervision.

6. The individual exhibits overt sexual behavior and exhibitionism.

7. The individual frequently displays antisocial behavior and has emotional instability with extreme and uncontrollable outbursts, destructive tendencies, and obsessive-compulsive behavior (fantasies, phobias, rituals).

Level VI

Individuals who reside at this particular ICF level require intensive nursing services and supervision on a 24-hour basis. All health services are under the direct supervision of licensed nurses who alternate three-hour shifts per day. These individuals can be ambulatory, mobile non-ambulatory, or non-ambulatory; however, health and motor problems do tend to be the major factors with these clients.

According to the DPW, the following functional levels apply to individuals at this level:

1. These individuals are severely or profoundly retarded and have minimal capacity for functioning in sensorimotor areas.

2. Some motor development is present.

3. They are totally incapable of self-maintenance and need complete care and supervision.

4. They display little or no speech and are usually noncommunicable.

5. They may exhibit extreme lethargy, passivity, or hypermobility.

6. Impulsive destructive behavior as well as self-mutilation tendencies may exist.

7. These individuals are subject to violent emotional outbursts.

8. Regressive response may occur and frequently complete infantile behavior.

Six-Beds-Or-Less

The state of Texas has adapted a new level of care which affects facility size and site location. Rule 326.35.03.055 or the "Six-Beds-Or-Less" Rule requires that requests for ICF certification be limited to a maximum of six beds per facility, and that the facility is located within an incorporated city. Also, the facility must be the only facility of its type within a three-mile radius, and access to community resources must be well documented. A comprehensive needs assessment is required to identify the number of developmentally disabled persons residing in the community and surrounding geographic area.

Case Management

A system of cooperative services becomes a necessary part of the alternative residential program as the movement digresses from a medical model of practice. Such a linkage of services enables group home residents to function fully and integrate into the community as mandated by their legal rights to treatment, and to live in the least restrictive environment. As a result, each individual resident must be dealt with on a case-by-case basis within the total service delivery system.

Case management services are mandated by the Developmentally Disabled Assistance and Bill of Rights Act of 1978 (P.L. 95-602). These services are defined as those efforts which assist developmentally disabled persons in gaining access to all needed support services, which coordinate the services provided, and which monitor the progress of clients over time. Such services are to be provided on a life-long basis.

Intagliata (1980) states that though P.L. 95-602 assures the developmentally disabled person comprehensive, coordinated, and appropriate services, the definition falls short of stipulating how need is to be determined. In keeping with current ideology in the service field, the definition of need must take into account the normalization principle and the developmental model. The services to be provided should be those which enable developmentally disabled persons to live a culturally "normal" life in the least restrictive environment and to achieve the highest level of growth and development of which they are capable.[41]

Stein (1980) defines case management as a mechanism through which individual needs are identified, plans to address these needs are formulated, and services necessary to attain the goals established in a case plan are mobilized.[42] Case management systems vary and are often based on the staffing patterns of each

148

program. Basically, case management activities include the following:[4]

1. Intake
2. Assessment
3. Case planning
4. Referral and follow-up
5. Case coordination, linking to services, monitoring services and service quality assurance
6. Implementation of the plan of care
7. Ongoing assessment
8. Plan of termination
9. Case recording
10. Supervision of staff
11. Advocacy

A review of case management models based on staffing patterns reveals the various approaches taken by agencies. One such model designates a single worker as case manager. This person is responsible for all case management activities with the exception of providing the direct services. Here the case manager is responsible for choosing, coordinating and monitoring the direct-care service agencies for their clients.

A second model takes the team approach to case management (i.e., an interdisciplinary team model). Teams of professionals (i.e., social workers, counselors, physicians, etc.) work closely together to provide the resident direct services through various professional skills and knowledge. One member of the team is assigned the task of case coordinator and is responsible for tasks such as arranging for the needed services, gathering information, describing individual progress in case plans, disseminating information to the other team members, calling team meetings, etc. The team approach has several advantages over the single worker case manager as it:

-provides continuous and coordinated coverage of services through more than one person.

-offers a variety of input from more than one source for more effective care and planning.

-eliminates the possibility of staff burnout so common with the single worker case manager model.

-keeps the resident from becoming too dependent on one staff member alone.

Another case management model divides tasks between two or more individuals. For example, one person may be assigned the responsibility of assessment and diagnosis, another may be responsible for linking the residents to services and then monitoring their progress for quality assurance of the services, while still another may be responsible for writing up each plan of care, instructing house parents in carrying out each plan of care for their residents, verifying that such plans of care are being followed for each resident, and so on. This model falls between the single worker case manager and the team concept.

Though models may vary, the agency tasks involved in case management are similar. A report from the National Home Caring Council (1976) lists the numerous case management tasks with which most agencies must contend.[43] The list is included here in order to give the service provider an idea of what is involved in providing services for each resident in their program.

1. Initial screening of application
2. Gathering information about eligibility
3. Making home visits to verify need or get information
4. Conducting financial reviews to determine fee
5. Ascertaining involvement potential of a responsible adult
6. Deciding upon eligibility for services
7. Determining nature of presenting problem or need
8. Making appropriate referral when applicant is found ineligible
9. Assigning priority to the situation (case)
10. Making a diagnostic assessment of the applicant's situation and needs
11. Obtaining medical or other professional diagnosis or orders
12. Determining action to be taken or services to be rendered

13. Determining hours, days, duration of service
14. Determining additional social or other services needed and making referral
15. Working with individual or family to establish service goals and objectives
16. Interpretation plan of service or role of aide to individual and/or family
17. Introducing aide to individual and/or family
18. Instructing aide in plan of care
19. Keep abreast of developments, changes in individual or family situation
20. Recognizing need for and obtaining consultation with another professional discipline
21. Investigating, evaluating emergency report from aide
22. Investigating complaint from individual or family being served
23. Evaluating complaint from individual or family being served
24. Coordinating work of aide and other professionals serving individual or family
25. Serving as liaison between aide and person responsible for plan of care
26. Confirming aide is receiving nursing and/or other supervision by contracting agency (if other than your own)
27. Maintaining contact with aide to identify case problems, new needs
28. Verifying that plan of care is being carried out
29. Conducting staff conferences to review case situations, utilization of services
30. Making diagnostic reassessment of individual or family situation and movement toward goals
31. Obtaining updated medical or other diagnosis, plan of care
32. Deciding upon revisions in plan of care
33. Reassessing hours, days, duration of service
34. Instructing aide in revised plan of care
35. Advising individual and/or family about revised plan of care
36. Determining newly developed needs for other services and referral
37. Making diagnostic assessment of appropriateness, timeliness of termination
38. Meeting and/or discussing with medical and other professionals to confirm termination
39. Discussing termination plan with aide
40. Discussing termination plan with individual and/or family
41. Observing performance of aide at work
42. Giving instructions to aide on how tasks should be done, how to organize work
43. Holding sessions with aide to discuss methods of work to implement plan of care
44. Being available to aide for consultation, assistance, help in seeking technical information
45. Assessing quality of aide's performance
46. Writing yearly formal evaluation of aide
47. Obtaining reports from nurse, client and others regarding aide's performance
48. Scheduling: selection of aide to be assigned
49. Scheduling: establishing work schedules of aides

50. Scheduling: replacement of sick aide
51. Scheduling: days off, vacation, leaves
52. Receiving and checking time sheets of aides
53. Maintaining case records
54. Assisting in development of the social worker's casework plan
55. Participating in joint planning, coordinating meetings pertaining to case
56. Assisting in development of nursing care plan
57. Assisting in developing supplementary services plan (e.g., arrangements for telephone reassurance, chore service, meals on wheels, etc.)

Case management focuses on individual cases. Service management is the support system for case management and the direct service activities. Service management involves the following functions and tasks that cut across all cases:[44]

1. Administrative supervision of direct service workers/recruitment and employment, training and staff development, scheduling of workers, evaluation of workers

2. Inter- and intra-agency coordination

3. Records and reports

4. Quality assurance for the total program

5. Community relations

The agency employing direct-care services is responsible for service management functions. For instance, if first aid training is given to houseparents, the agency is responsible for such tasks as seeing that such training covers all required areas, is given by qualified instructors, etc.

At the very center of the casemanagement system is the service delivery mode. The mode can be viewed as a pathway for clients to follow in receiving needed services. The Center for Urban Affairs and Community Services at North Carolina State University (1978) lists six functions in the client pathway as follows:[45]

1. Intake/Entry

Intake/Entry involves the initial general assessment of the residents, a discussion of the residents' problems a listing of services the residents will require, and a completion of the necessary forms (i.e., eligibility forms). Depending on the extent of the resident's needs of problems, he either exits from the system through information services and referral or he is routed through the Emergency function.

Emergency. The emergency function is for those clients who have time-critical problems and need services immediately. Once the time-critical functions are met, the case manager and client move on to the Problem Assessment function (no. 2).

Self-Service. The self-service function is for clients that do not need case management but who do need information and possibly a referral for specific services. Once this has been accomplished, the client can usually exit from the system.

2. Problem Assessment

At this point, the client and case manager make an extensive assessment of needs and problems. The client is viewed in a holistic manner, and an attempt is made to see the client's situation as a whole rather than as fragmented parts.

3. Service Planning

A comprehensive plan is formulated between the client and the case manager for receiving services, the results desired, and an estimated time frame for completion or termination of the services.

4. Service Provision

Service Provision is the actual delivery of direct services as formulated in the service plan. This is accomplished through direct service providers (i.e., educators, doctors, rehabilitation specialists, etc.) and is directed toward specific client goals. The case manager keeps a constant check on services to see that the client's goals are met.

5. Monitoring

The Monitoring function is closely tied to the Service Provision function. It provides for continuous checking and re-checking of the Service Provision efforts by the case manager.

6. Follow-Up

At a designated time following the completion of the Service Provision function, the client is contacted for a report on his current status. If the client has unmet needs, or if earlier problems have recurred, the client may reenter the system to have these needs resolved. The Follow-up function also provides a means of checking on quality assurance of the services.

Finally, the service provider should be aware that there are barriers that could block case management efforts. Six such barriers could include the following:[46]

1. Economic barriers - those who cannot pay for services cannot get them
2. Cultural barriers - how the agency is viewed by different groups within the community; for example, as a "welfare agency"
3. Language barriers - prevent open inquiring about services
4. Information barriers - when the community is not aware of the agency's existence or purpose
5. Professional barriers - imposed by professional traditions and referral practices of physicians and other health and social service providers
6. Agency policy barriers - when age, diagnosis, geography or similar policy decisions prevent access to needed services

According to the National HomeCaring Council, these barriers can be easily removed by such tactics as educating the public, utilizing advocacy activities within the community, assuring that written intake policies and eligibility criteria are consistent, hiring multilingual and/or multicultural staff (if necessary), and correcting inefficient business practices within the agency (i.e., inexperienced personnel, poor record keeping, maintaining high caseloads, excessive paperwork, poor supervision, etc.). Stein (1980) stresses that effective case management should:[47]

1. increase client access to services

154

2. make services more available by developing needed programs and by modifying eligibility requirements to make services more universally accessible

3. increase the responsiveness of service providers to community and client needs

4. facilitate a more holistic approach to client problems by integrating categorical programs which, by their very nature, reinforce a view of clients in terms of the separate objectives of each program

5. increase the cost effectiveness of service programs, and

6. improve accountability to legislators, administrators and consumers

As for the case managers who are the human links between their clients and direct services, their functions can be divided into three essential tasks: to stay aware of the comprehensive needs of their clients; to link their clients to services; and to monitor constantly the services provided to their clients.

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Chapter VI

Programmatic Matters

The training of staff members to deal with the rigors of group home living is perhaps one of the most important components of the alternative living program. Recent research indicates that trained staff members tend to enhance the success of such programs. For instance, Schinke and Landesman-Dwyer (1981) found that group home staff who had gone through the rigors of a training program showed more knowledge of behavior management principles and procedures; they also displayed less job dissatisfaction, better attitudes toward group home residents, and improved behavior as measured by on-site observation.[1]

Staff turnover is a major problem that plagues the residential programs, and problems which contribute to this high turnover rate include:

1. low skill levels of staff members
2. low staff morale
3. low pay scales
4. no prospects for advancement
5. staff burn-out
6. poor staff/client interaction
7. lack of support staff

Schinke and Landesman-Dwyer concluded that low job satisfaction and high staff turnover rates could possibly be remedied through some type of staff training program; in addition, residents could profit from the educational, vocational, and social benefits resulting from the implementation of such programs.

The service provider who wishes to establish a residential program should examine various existing training programs prior to "setting up shop." Most training programs today stress a competency-based curriculum which involves a set number of hours to be taken for credit. Of course, the underlying focus of training programs is to assure quality care for persons with developmental disabilities who reside in alternative living environments.

Many states are now enacting legislation that requires plans for statewide training programs and curriculums for training the staff of residential care facilities. For example, California's Department of Developmental Services implemented a plan for a statewide program to train staff of residential facilities under legislative mandate. Known as the Residential Services Specialist Training Program, the comprehensive curriculum provides direct care staff with a core of knowledge and information necessary to offer their residents quality care and supervision. Each unit contains instructional material that is divided into goals, major-topic and key-discussion areas, learning objectives, suggested methods of instruction, criteria to evaluate the student's performance, complete topic outlines, and references for the instructor's use. The curriculum is taught at the community-college level by specialists from local and regional agencies.

Other states have initiated on-site training programs which use informal settings to provide staff members with familiar and comfortable surroundings in which to learn the necessary skills. For instance, the Florida Association of Rehabilitation Facilities has established a program to allow for a free-flowing interchange of ideas among the trainees. The training utilizes the active participation of the trainees as a means of insuring that the information provided is meaningful and that learning is occurring[2].

The Florida Association sponsors a two-and-a-half day workshop for group home staff, and the training program is broken down into eight modules:

1. Normalization
2. An Overview of Developmental Disabilities
3. Community Resources and Relations

4. Teaching New Behavior
5. Behavior Management
6. Home Management
7. Leisure Time Education
8. Human Sexuality

Though a two-and-a-half day workshop may seem too brief a time period in which to learn the necessary skills, this particular program provides the staff with a comprehensive introduction to the basic skills and information needed to operate a group home. This type of workshop appears extremely useful for those staff members who are already employed and who have worked for some time as direct-care providers with the handicapped. They are already familiar with most of the procedures of group home maintenance and operation and may require only a limited amount of new information to help in providing their clients with quality care.

For those staff members who are new and/or have not had the experience of dealing with mentally retarded individuals, a more detailed curriculum should be utilized. Training for Independent Living (TIL) is a comprehensive training manual designed to teach handicapped adults the skills necessary for independent community living. TIL was developed through a grant from the California State Department of Rehabilitation and was sponsored by the Ventura County Association for the Retarded, Inc.

Designed as a transitional living situation, the TIL training program is designed for six months, after which the trainees move on to more independent living arrangements (i.e., apartments). The most important function of staff members is that of role models as they guide the trainees through the rigors of the program. Staff members are expected to have experience in apartment living so they can relate to the fears and concerns of the trainees.

An excellent training program aimed more specifically at the group home parent model is The Life Project sponsored by the Harry A. Waisman Center on Mental Retardation and Human Development at the University of Wisconsin-Madison. The Life Project consists of eight separate manuals divided into the following units:

1. Introduction to Mental Retardation and Community Living
2. Home Management
3. Health and Hygiene
4. Behavior Management
5. Sexuality
6. Recreation and Leisure Time
7. Community Resources and Relations
8. Social Competency

Each unit employs a self-teaching design of programmed instruction in which the group home parent can work at his/her own pace. The Life Project provides the group home parent with useful knowledge and practical skills for supervising and training his residents.

The following outline is based on material researched and gathered from various training sources and programs and is indicative of the content of most training manuals on the market today. Each of the nine units contains material necessary to teach group home residents the essentials in independent living. For easy reference, resource references are included at the end of each unit along with publication addresses.

UNIT I

I. Normalization Principle

   A. Definitions

      1. Bengt Nirje - making available to all mentally retarded people patterns of life and conditions of everyday life which are as close as possible to the regular circumstances and ways of life of society.

      2. Wolf Wolfensberger - utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible.

   B. Components of the Normalization Principle (Nirje)

      1. Normal Rhythm of the Day

      2. Normal Rhythm of the Week

      3. Normal Rhythm of the Year

      4. Normal Experience of the Life Cycle

      5. Normal Respect

      6. Living in the Bisexual World

      7. Normal Economic Standards

      8. Normal Environment Standards

   C. Application of the Normalization Principle/Residential Services

      1. Architectural-Environmental Implications

         a. The meaning of a building

         b. The focus of convenience of a building

         c. Architectural implications of certain role perceptions of the client-users of buildings

         d. Internal design of a building

      2. Application to Residential Services

         a. Integration

         b. Smallness

        c. Separation of the domiciliary function

        d. Specialization

        e. Continuity

    3. Rights to Self-determination and normal risks

    4. Application to Vocational Training

    5. Application to Socio-Sexual Relationships

II. Developmental Model (Piaget)

    A. Definition

        1. All individuals are capable of growth and development.

        2. Growth or changes in behavior follow a developmental hierarchy.

        3. Behavior acquisition moves from simple to more complex responses.

        4. More complex behavior is the result of coordination or modifying simpler component response forms.

        5. All handicapped persons can learn and develop with appropriate programming.

    B. Application of the Developmental Model

III. Other (historical) Models (Management Models)

    A. The Sickness Model

    B. The Menace Model

    C. The Pity Model

    D. The Charity Model

    E. The Subhuman Model

IV. Resources/References

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P.O. Box 140496
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Unit II

I. Overview of Mental Retardation

A. Mental Retardation (AAMD Definition)

...refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

1. Levels of Mental Retardation

a. Intellectual Functioning (Measured Intelligence, IQ)

1. Mild
2. Moderate
3. Severe
4. Profound

b. Adaptive Behavior

1. Sensorimotor skills
2. Speech and communication
3. Socialization (social interaction with others)
4. Self-care/self-help
5. Application of basic academic skills in daily life activities
6. Application of appropriate reasoning and judgement in mastery of the environment
7. Social skills (participation in group activities and interpersonal relationships)
8. Vocational and social responsibilities and performances

2. Classification of Mental Retardation (Grossman, 1973)

To be classified as mentally retarded, a person must:

a. have intellectual functioning that is more than two standard deviations below the norm (@ 68 IQ),
b. become mentally retarded as a result of an injury, disease, or problem occuring either prenatally or during the developmental years, and
c. be impaired in his ability to adapt to his environment.

3. Causes of Mental Retardation (Five Areas)

a. Genetic Causes (Inherited)

1. Down's Syndrome
2. Phenylketonuria (PKU)
3. Galactosenia
4. Cranial Defects (Hydrocephaly, Microephaly)

b. Pre-Natal (Before birth)

166

1. Infections/Virus (toxoplasmosis, syphilis, rubella, cytomegalovirus, and herpesvirus)
2. Rh factor (blood incompatibility)

c. Perinatal (At birth)

1. Birth injuries
2. Anoxia
3. Premature birth

d. Postnatal (infancy and early childhood)

1. Meningitis
2. Encephalitis
3. Head Injuries

e. Cultural and Environmental Deprivation

f. Developmental Disability (Grossman, 1973)

> ...a developmental disability manifests itself prior to 22; is expected to continue indefinitely; results in substantial functional limitations of three or more of the major life activities (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency); and requires care and treatment for an extended period.

a. Mental Retardation

b. Cerebral Palsy

c. Epilepsy

d. Autism

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UNIT III:

I. Resident-Staff Interaction

   A. Group Process/Theories

      1. Membership/Group Living

      2. Group Responsibility/Leadership

      3. Group Norms/Standards/Pressures

      4. Group Goals

      5. Communication/Theories

      6. Role Types in Groups

         a. Group Task Roles. Facilitation and coordination of group problem solving activities (i.e., Roles: Encourager, Compromiser, etc.).

         b. Group growing and vitalizing roles. Building group-centered attitudes and orientation.

         c. Antigroup Roles. Tries to meet felt individual needs at the expense of group health rather than through cooperation with group (i.e., Roles: Aggressor, Blocker, Recognition-Seeker, etc.).

   B. Role of the Houseparent(s) (discussion)

      1. A person who, like the other members of the home, lives there

      2. A person who acts as a role model

      3. A person who helps others keep the house in order by showing and doing

      4. A person who helps house members interpret their responsibilities within the home and who works with people on their responsibilities

      5. A person who helps plan and prepare meals with the full participation of other house members

      6. A person who can answer questions

      7. A person who knows how things in the house work (lights, plumbing, etc.)

      8. A person who gives good advice on personal appearance

      9. A person who sometimes goes places with house members

10. A person who knows where things are located in the house and community

11. A person who can explain and interpret various aspects of community life

12. A person who helps the program director and house members decide what individuals need

13. A person who shows people how to do simple things

14. A person on whom one can depend for assistance, advice, or interpretation

15. A person who is respected for what she does

16. A person who is invited and expected to attend conferences, workshops, and training

17. A person who sees a home first and a program second

18. A person who makes home life stable

19. A person who advises auxiliary staff as to how things work

20. A person who helps organize things in the house

21. A person to talk to

22. A person who can advise or make judgements

23. A person who knows what is supposed to be happening

24. A person who shares his/her own friends with house members

25. A person who accepts the friends of house members

26. Other roles (discussion period)

C. Houseparent Role Models (Discussion)

1. Mother/Father Substitutes

    a. Power: Good exertion of power vs. Bad exertion of power

    b. Overprotective vs. lenient

    c. Key influence: Resident-oriented caretaker vs. institution-oriented caretaker

2. Teacher

3. Disciplinarian: Fair vs. "Heavy-Handed"

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   b. Overprotective vs. lenient

   c. Key influence: Resident-oriented caretaker vs. institution-oriented caretaker

2. Teacher

3. Disciplinarian: Fair vs. "Heavy-Handed"

4. Counselor

5. Dedicated to residents vs. non-caring (staff who are only there to put in an eight hour day and collect their pay)

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UNIT IV

I. Behavior Management

A. Definition

1. Behavior - Any observable or measureable movement of the organism or of its parts, including external movements, internal movements and their effects and glandular secretion and their effects.

2. Behavior - the result of a person interacting with his environment.

3. Respondent Behavior - unlearned, reflexive, automatically responding to specific stimuli.

4. Operant Behavior - learned, under voluntary control, influenced and controlled by events or consequences that follow its occurrence.

B. Behavior Modification

1. Definition - a method of changing observable behavior through reinforcement or reward.

2. Basic Concepts (Discussion)

a. The Principle of Reinforcement - if the results of behavior are positive, the behavior will likely be repeated. This principle determines what stimuli or cues in the environment are important to the individual and what the individual will do or not do.

b. The Principle of Stimulus Control - certain cues or parts of the individual's environment or the world he lives in determine the things he will do and when he will do them.

3. Operant Conditioning - developing voluntary behavior in people.

a. Reinforcement - a stimulus or reward presented following a response which increases the rate of the response.

(1) Contingent Reinforcement - a reinforcer is presented if, and only if, a specified response occurs.

(2) Positive Reinforcement (Rewards)

(a) Social reinforcers - praise, approval, affection, etc.

(b) Tangible Reinforcers - material items that can be experienced with the senses, food, candy, toys, games, etc.

(c) Tokens - anything that can be exchanged for tangible reinforcers or reinforcing events, check marks, points, etc.

Token Economy Program - an operant conditioning program whereby residents receive tokens, such as plastic tokens resembling real money in denomination, color and size, for improved performance in grooming, manners, personal hygiene, etc. or for those requirements done satisfactorily. The tokens could then be exchanged for privileges such as an extra hour out at night, dances, movies, treats, etc.

(d) Intrinsic reinforcers - satisfactions inherent in performing and activity itself.

(e) What to remember when using rewards:

(1) Immediacy - a reward should be given immediately upon the client's completion of the targeted behavior.

(2) Consistency - be consistent in giving the reward only after the desired behavior has occurred.

(3) Strength - the reward must be something the client wants. It must be important enough for the client to work to obtain it.

(4) Amount - too much reward will lose effectiveness. For example, if the client is full from dinner, food will not be an effective reinforcer.

(5) Age Appropriateness - do not reward an adult client with a play doll, coloring books, etc. The reward should fit the age.

(3) Negative Reinforcement - any stimulus which, be its removal, strengthens the response that follows.

(a) Use of punishment

(b) Discipline (Loss of Privileges)

(4) Extinction - method employed to ignore certain undesired behaviors in an attempt to weaken the behavior. The procedure involves withholding an accustomed reinforcer.

b. Shaping - molding or developing simple behavior into complex behavior. Can be used to teach toilet training, dressing skills, language skills, social-recreational skills, educational skills, and vocational skills.

(1) Successive Approximation - a shaping technique used to teach a single behavioral component in a step-by-step fashion. Rewarding partial success of behavior similar to that desired and gradually demanding more correct behavior.

(2) Chaining - a shaping technique used to teach complex behaviors, such as dressing, one component at a time. Each component can be thought of as a link that makes up the behavioral chain.

c. Prompting and Fading

(1) Prompting - use of a cue that clearly communicates to the client.

(a) Verbal prompts
(b) Gestural prompts
(c) Physical prompts
(d) Demonstration (modeling)

(2) Fading - the gradual change in a stimulus or cues, aids/psychological and/or physical. Fading in cues is gradually introducing new cues into the client's environment. Fading out cues is gradually eliminating cues from the client's environment (i.e., fading in or out prompts used by the instructor).

d. Modeling - observational learning, the client observes the behavior of a "model" and imitates or performs responses similar to those of the model. The client learns specific behaviors and related consequences through modeling.

II. Teaching New Behaviors

A. Steps in teaching a new behavior

1. Target the behavior...define and state operationally the behavior to be changed.

2. Obtain a baseline of operant level of the behavior you wish to promote.

3. Prompt or arrange the learning situation facilitatively for the target response.

4. Identify potential reinforcers.

5. Shape and/or reinforce desired behavior immediately and continuously upon its occurrence.

6. Keep records of the reinforced behavior.

B. Prompting desired and/or adaptive behavior

1. Reinforce successive approximations of the target behavior (shaping).

2. Arrange and vary stimulus conditions so that the desired behavior occurs (fading).

3. Observe and imitate the responses of a model.

4. Use contingency management to increase a low-probability behavior by following its occurrence with the opportunity to participate in a high-probability behavior. Contingency management is the control of reinforcers in an attempt to increase or decrease the frequency of a response. Possible examples of low-probability behaviors might be hanging up clothes, doing one's homework, cleaning one's room. High-probability behaviors might include playing outside with friends, watching a favorite television show, etc.

5. Use punishment to inhibit the undesirable behavior and simultaneously reinforce the desirable behavior.

C. Issues in the use of behavioral modification procedures

1. Landmark Cases

a. Kaimowitz vs. State Department of Mental Health (psychosurgery)

b. Knecht vs. Gillman, Mackey vs. Procunier, & Wyatt vs. Stickney (treatment programs using noxious stimuli, electric shock, etc.)

2. Staff Qualifications/Use of Consultation

3. Procedures for Strengthening Behavior...use of positive reinforcers.

a. Intrinsic reinforcement

b. Social reinforcement

c. Artificial reinforcement - i.e., token economics should not become the objective itself.

d. Appetitive reinforcement - using food or liquids. No deprivation of food can be used that is less than what the normal intake would be on a daily basis.

4. Procedures for Weakening Behavior

   a. Eliminating maladaptive behavior

   b. Guidelines for procedures which can help promote more normal development by weakening maladaptive behavior.

      (1) Avoidance of inappropriate behavior...by providing a more stimulating environment (i.e., providing materials, activities, social interaction, etc.). Do not seek appropriate behavior through punishment; rather, provide the environment.

      (2) Extinction of inappropriate behavior...train staff to provide materials, organize activities, prompt and facilitate appropriate behaviors while ignoring inappropriate behaviors.

      (3) Stress in-service training on behavior management techniques.

5. Procedures for the Humane Management of Behavior Problems

   a. Problems that interfere with individual and group development/ Behavioral characteristics

      (1) The biggest problem and the frequency of such behavior

      (2) Four categories of maladaptive behavior

         (a) Self-injurious behavior
         (b) Behavior injurious to others
         (c) Behavior that damages property
         (d) Unusual or disruptive behavior

   b. Procedures used to weaken inappropriate behavior/References

      (1) Time-Out (Barton, E.S.; Bostow, D.E.; Wolf, N.M.)

      (2) Response Cost and Effort (Barrish, H.H; Jacobson, J.M; O'Brien, F.; Phillips, E.L.; Sailor,W.)

      (3) Overcorrection (Fox, R.M; Azrin, N.H; Webster, D.R.)

      (4) The Application of Painful Stimuli (Corte, H.E.; Lavaas, O.I; Risley, T.R.)

      (5) Public Accountability/Acceptance of Procedures/Moral Issues and Social Repercussions

      (6) Guidelines for use of more severe treatment

         (a) Seclusion time-out in a locked room/rules governing room use, etc.

(b) Contingent electric shock

(7) Managing Aggressive Behavior*

(a) Non-physical techniques to calm and help an agitated client regain behavioral control (i.e, identifying behavior changes, stress, what causes stress, and stress management).

(b) Physical techniques to protect the client, others and self (i.e., releasing hand grasp, a grasp from behind, bear hugs, protecting oneself while pinned to the ground, etc.).

(c) Applying personal restraints and secluding an aggressive or combative client in accordance to regulations (i.e., procedures for following a client to the ground applying personal restraint, safely getting a client to a standing position, etc.).

(d) Techniques for recovering objects from aggressive persons (i.e., verbal intervention, procedure used to protect self and others from a client using an object to inflict pain and injury, etc.).

*Based on a required training module for all direct-care staff in the *Prevention and management of aggressive behavior* (Training Standards), under the Texas Department of Mental Health and Mental Retardation's Client Abuse and Neglect Rule, 302.04.19.007.

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UNIT V

I. Special Concerns of the Mentally Retarded Youth

  A. Anatomy and Reproduction

    1. Male Reproductive System

    2. Female Reproductive System

    3. Menstrual Cycle/Care and Hygiene

    4. Health Problems

      a. Vaginitis

      b. Cystitis

      c. Self-Examination of Breasts

      d. When to see your physician

    5. Birth Process

      a. Fertilization

      b. Fetal Development

      c. Birthing Methods

      d. Labor/Delivery

      e. Concerns about Child Birth

      f. Prenatal Care

      g. Postnatal Care

    6. Infant Care

      a. Self-help care of your baby

      b. When to consult your physician

      c. Immunizations

  B. Sexual Behavior/Intimacy

    1. Viewing the Mentally Retarded Individual as a Sexual Being

    2. Societal Sex Values

    3. Friendship/Dating
    4. Acceptable/Unacceptable Sexual Behavior
    5. Loving and Caring
    6. Masturbation/Privacy/the Appropriate Place
    7. Exhibitionism
    8. Homosexuality
    9. Promiscuity
    10. Exploitation

C. Marriage

    1. A Sharing Relationship
    2. Husband/Wife Responsibilities and Roles
    3. Family Planning/Genetic Counciling
    4. Parenting

D. Birth Control

    1. Types of Contraceptives/Advantages-Disadvantages of each method (discussion)
        a. Birth Control Pills
        b. IUD's
        c. Diaphragm and Jelly
        d. Suppositories
        e. Foams and Jellies
        f. Injectables (synthetic hormones)
        g. Sterilization
            (1) Tubal Ligation
            (2) Vasectomy
        h. Condoms
    2. Abortion (Pros and Cons)

E. Venereal Disease/Signs/Treatment

1. Syphilis

2. Gonorrhea

3. Herpes Genitalia

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New York, NY 10011

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Ardmore, PA 19003

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North Scituate, MA 02060

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1220 Sansom
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866 Third Ave.
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2709 Ave. E. East
Arlington, TX 76011

Audio-Visuals

"On Being Sexual." Includes discussions by Dr. Sol Gordon, parents, clients, health care staff, and care providers on the subject of sexuality and the mentally retarded individual. (Color, 20 min.)
Write: The Stanfield House
P.O. Box 3208
900 Euclid Ave.
Santa Monica, CA 90403

"The ABC's of Sex Education for Trainable Persons." Depicts actual training sessions on teaching mentally retarded persons about their reproductive systems, sexual concerns, responsibilities and appropriate behavior. (Color, 20 min.)
Write: Educational Division
Hallmark Films and Recordings, Inc.
1511 East North Ave.
Baltimore, MD 21213

"Mental Retardation and Sexuality." Teaches the basic concepts of human sexuality. (20 min.)

Write: Planned Parenthood Assoc. of Southeastern Pennsylvania
1220 Sansom
Philadelphia, PA 19107

UNIT VI

I. Individual Program Plan, Individual Habilitation Plan

A. Definition - individually written plans of education and training for clients.

B. Components

1. Goal statements - what the client is being expected to achieve, or how he/she will change as a result. Goals:

    a. are written in broad, general terms.
    b. state the direction of the program in a positive manner.
    c. establish general guidelines for treatment.
    d. reflect progressive behavior.

2. Objectives - statements that are specific and short-term in nature and contribute to the achievement of the broader goals. Objectives:

    a. break down goals into smaller and more manageable parts.
    b. describe an outcome/the behavior you want the client to display at the completion of the training.
    c. state, in behavioral terms, a performance of what the learner will be doing when he demonstrates mastery of the objective.
    d. are time-linked. That is, objectives indicate how long it will take the client to learn the targeted behavior.

3. Strategies - the services, training, and/or procedures used to facilitate the achievement of the goals and objectives. Strategies:

    a. specify who is responsible for carrying out the plan.
    b. indicate when and how the plan is to be implemented.

4. Evaluation - the methods (and schedules) that will indicate the extent to which goals and objectives are actually being achieved (feedback on client progress). Evaluation procedures:

    a. can include standardized tests, rating scales, observations of behavior, records of daily performance, etc.
    b. detect progress toward the achievement of the objectives.
    c. provide systematic and objective evaluation.
    d. pinpoint weak points of the training procedures and allow for correction.
    e. are essential for acquiring funding and are required by law.

C. Legal mandate

1. Section 112 of the Developmental Disabilities Assistance and Bill of Rights Act makes it manditory for each program receiving DD funding to have an habilitation plan on each client.

2. Legal requirements (i.e., the plan must be in writing; must contain clearly stated goals, objectives, strategies, and evaluation procedures; must indicate specific habilitation services used; must undergo annual review and revision, etc.).

D. Interdisciplinary Team Approach

1. Definition - persons of various professional backgrounds and disciplines work together to formulate and implement one overall program for each client. Direct-care staff are essential to the interdisciplinary team approach.

2. Roles/Responsibilities

a. Diagnose, evaluate, plan and implement IPP's.

(1) Developing a strengths/needs list on each client

(a) Strengths - what the resident can and likes to do.
(b) Needs - what the service provider and the client would like to accomplish. The strengths are used to meet the client's needs.

(2) Writing goals and objectives based on strengths/needs list.

(3) Developing strategies and devising evaluations.

(a) Process evaluation - measures whether the strategies are working (that is, the training procedures).

(b) Product evaluation - measures whether the objectives are being met (that is, the outcome of the training).

b. Responsible for including the individual client, and as appropriate, the individual's family and/or advocate in the planning processes.

c. Share and discuss information and recommendations of all participants so that decisions are made by the entire team and not individual members.

d. Review the client's progress towards the objectives developed by the team.

e. Re-evaluate the client's need and the appropriateness of the individual's program in the light of his or her progress.

f. Modify (if necessary) the objectives and/or program accordingly.

E. IPP Implementation

1. Definition - refers to the provision of services in accordance with the IPP. Systematic and organized services and intervention that are designed to enhance the development of a developmentally

INDIVIDUAL PROGRAM PLANS

Adopted from Individual Program Planning with Developmentally Disabled Persons

TIME PERIOD ______________ TO ________________

CLIENT: ________________________________

CASE NUMBER: ________________________

CASE COORDINATOR: _____________________

D.O.B.: ____________________________

GOAL	OBJECTIVE	STRATEGY	PROGRAM(S)	EVALUATION PROCEDURES	BARRIERS	OBJECTIVE ACCOMPLISHED (DATE)

IPP

NAME ______________________ COORDINATOR ______________________

DATE ______________________ ______________________ CASE # ______________________

DEVELOPMENT

GOALS	OBJECTIVES	MODES OF INTERVENTION	EVALUATION PROCEDURE

CURRENT PROGRAMMING:

RECOMMENDATIONS:

SIGNATURE OF CLIENT COORDINATOR ______________________

SIGNATURE OF PARENT ______________________

SIGNATURE OF CLIENT ______________________

IPP

NAME: ____________________
CASE #: ____________________
DATE: ____________________

STAGE: ____________________
____

SHORT RANGE GOALS	TECHNIQUES	EVALUATION PROCEDURES	PERSON RESPONSIBLE

IPP

Name ____________________ Date ______________ Client # ___________

STRENGTHS	NEEDS
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I. Goal: ____

A. Objective: ____

1. Strategy: Who: ________________________ When: ____________

What: ____

____

a. Process Evaluation: ______________________________

____

b. Outcome Evaluation: ______________________________

2. Strategy: Who: ________________________ When: ____________

What: ____

____

a. Process Evaluation: ______________________________

____

b. Outcome Evaluation: ______________________________

Con't.

3. Strategy: Who:______________ When:______________

What:____

____

a. Process Evaluation:______________________________

____

b. Outcome Evaluation:______________________________

II. Goal:____

A. Objective:____

____

1. Strategy: Who:______________ When:______________

What:____

____

a. Process Evaluation:______________________________

____

b. Outcome Evaluation:______________________________

2. Strategy: Who:______________ When:______________

What:____

____

a. Process Evaluation:______________________________

____

b. Outcome Evaluation:______________________________

3. Strategy: Who:______________ When:______________

What:____

____

a. Process Evaluation:______________________________

____

b. Outcome Evaluation:______________________________

disabled individual. These services and interventions must be provided in accordance with a definite plan that is based on a determination of the individual's developmental status and needs (AC/MRDD definition, 1981).

2. Developmental model - an appropriate environment for learning and specific opportunities (i.e., services) must be provided if optimal growth and development are to occur.

3. Individual Program Implementation Components

    a. Physical Development and Health, Self-Care Skills
    b. Habilitation, Education, and Training
    c. Mobility
    d. Work and Employment
    e. Recreation and Leisure, Social Skills
    f. Behavior Management

F. Evaluation and Assessment - an empirical process that determines if, and to what degree, an individual has developmental deficits, and what interventions and services are needed to enable the individual to move toward increasingly independent functioning (AC/MRDD, 1981).

1. Comprehensive assessment (examples)

    a. Communication

        (1) Physical communication
        (2) Language
        (3) Linguistic

    b. Physical development

        (1) Gross motor/fine motor
        (2) Basic motor
        (3) Motor activities
        (4) Body-motor

    c. Self-help

        (1) Drinking
        (2) Eating
        (3) Toileting
        (4) Dressing

    d. Community orientation

        (1) Daily living
        (2) Semi-independent living
        (3) Household responsibility
        (4) Home adjustment
        (5) Household business

    e. Vocational

  - (1) job training

- f. Learning (academic)
  - (1) Cognitive
  - (2) Memory
  - (3) Knowledge
  - (4) Thinking
  - (5) Reasoning
  - (6) Conceptual

- g. Personality
  - (1) Affect
  - (2) Emotion
  - (3) Awareness
  - (4) Attention span
  - (5) Distractibility

- h. Self-Care Skills
  - (1) Eating, food preparation
  - (2) Toilet
  - (3) Dressing
  - (4) Hygiene
  - (5) Grooming
  - (6) Money management
  - (7) Safety

- i. Social
  - (1) Socialization
  - (2) Interaction
  - (3) Social maturity
  - (4) Social awareness
  - (5) Response to others
  - (6) Social skills
  - (7) Cooperation
  - (8) Participation
  - (9) Discipline
  - (10) Withdrawn
  - (11) Antisocial

- j. Behavior problems
  - (1) Irritability
  - (2) Disruptive
  - (3) Hyperactivity
  - (4) Assaultive
  - (5) Maladaptive
  - (6) Violent
  - (7) Hostility

k. General skill areas (AC/MRDD, 1981)

(1) Motor skills
(2) Sensorimotor skills
(3) Cognitive skills
(4) Communicative skills
(5) Social skills
(6) Affective (emotional development)

2. Assessment instruments

a. Intelligence

(1) Wechsler Adult Intelligence Scale (WAIS)
(2) Wechsler Intelligence Scale for Children (WISC)
(3) Stanford-Binet Tests

b. Adaptive Behavior

(1) AAMD Adaptive Behavior Scale (ABS)
(2) Vineland Social Maturity Scale (VSMS)
(3) Caine-Levine Social Competency Scale
(4) Balthazar Scales of Adaptive Behavior
(5) Minnesota Developmental Programming System

3. Necessity of assessment

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5101 Wisconsin Ave., N.W.
Washington, DC 20016

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Write: Robert H. Bruininks, Project Director
Department of Psychoeducational Studies
College of Education
University of Minnesota

The value-based skills training curriculum, 9 training modules designed to assist community-based mental retardation preservice and inservice training programs develop competencies necessary to work with persons who have developmental disabilities.
Write: Media Resource Center
Meyer Children's Rehabilitation Institute
444 South 44th St.
Omaha, Nebraska 68131
Phone: (402) 559-7467.

UNIT VII

I. Program Maintenance/Daily Living Activities

A. Household Management

1. Housekeeping

   a. Laundry and ironing
   b. Sweeping, dusting, and general cleaning
   c. Household cleaning products needed (i.e., cleansers, mop, broom, dust pan, furniture polish, vacuum cleaner, etc).

2. Yard, lawn maintenance

   a. How to operate a lawn mower
   b. Raking up mowed grass and leaves, pulling up weeds, watering the lawn, etc.
   c. Garden maintenance (i.e., what to plant, when to plant, how to plant, how often to water, etc.)

3. Meal planning

   a. Planning a daily menu

      (1) Breakfast
      (2) Lunch
      (3) Dinner
      (4) Snacks

   b. Nutrition - Balanced meals/purchasing food

      (1) Dairy items
      (2) Fresh fruits and vegetables
      (3) Meats, fish, poultry
      (4) Breads, cereals
      (5) Special diets (i.e., low sodium, etc.)
      (6) Comparative food shopping
      (7) Selecting brand names/judging quality foods

   c. Shopping list items

      (1) Food items - four basic food groups
      (2) Household cleaning items
      (3) Hygiene/health items
      (4) Sundries

4. Meal preparation

   a. Kitchen skills

      (1) How to use the stove, electric can opener, toaster, etc.
      (2) Basic kitchen cleanliness and safety, washing vegetables, food storage, cleaning up, etc.

5. Paying monthly bills (on time)

   a. Monthly bills

      (1) Rent
      (2) Gas/electric/water/sewage
      (3) Monthly and/or weekly magazine or newspaper payments
      (4) Charge card payments
      (4) Other

   b. Tips on how to cut down on monthly bills, energy conservation tips, etc.

6. Opening a bank account

   a. Savings account

      (1) Types of savings plans (i.e., 90-day accounts, 1-year accounts, etc.)
      (2) Interest
      (3) Making a deposit or withdrawal

   b. Checking account

      (1) Purchasing checks
      (2) How to use a checkbook

         (a) Writing checks to pay bills, purchase items, etc.
         (b) Date, check number, who the check is issued to, writing the amount of the payment, signing the check
         (c) Keeping account of written checks, how to compute the balance
         (d) Making deposits and/or withdrawals

B. Personal Health and Hygiene

1. Personal grooming

   a. Bathing and showering
   b. Hair care
   c. Skin care
   d. Nail care
   e. Cosmetics
   f. Shaving/male and female
   g. Brushing and flossing teeth/mouthwash

2. Female physical hygiene

   a. Tampons/proper use and disposal
   b. Sanitary napkins/proper use and disposal
   c. Disposable douche/proper use

3. Personal Health/Common Health Problems

   a. Setting up a daily exercise routine
   b. Weight control through diet and exercise
   c. Proper posture
   d. Medical checkups and everyday health tips
   e. Preventive medicine
   f. Common colds
   g. Constipation/diarrhea
   h. Athlete's foot
   i. Head and body lice
   j. Taking temperatures (i.e, oral, under the arm, rectal)
   k. How to read a thermometer

4. Seizures/Common Types/Treatment

   a. Grand Mal Seizure - major motor seizures in which the individual loses consciousness and has jerking movements of the arms and legs.
   b. Petit Mal Seizure - minor motor seizures in which the individual loses consciousness, but can feel or do a variety of things unaware of any activity (i.e., chewing, lip smacking, starting, buzzing or ringing in the ears, etc.)
   c. Psychomotor Seizure - the individual loses consciousness, but can feel or do a variety of things unaware of any activity (i.e., chewing, lip smacking, staring, buzzing or ringing in the ears, etc.)

5. Treatment of Seizures/Guidelines

   a. Keep calm
   b. Do not try to restrain the movements of the person/avoid injury
   c. Clear the area around the person/put something soft under his head
   d. Turn the person's head to the side to allow saliva or vomit to flow freely/loosen necktie or tight clothing
   e. Do not open the clenched jaws
   f. Do not give the person anything to drink
   g. Stay with the person until the seizure is over and he is fully recovered
   h. If another seizure occurs immediately after a major seizure, call a doctor
   i. For the doctor's information, note the frequency, duration and type of seizure

6. Conditions that May Increase the Frequency of Seizures

   a. Irregular use of medication
   b. Emotional stress/reactions (i.e., excitement, fear, frustration, etc.)
   c. Illness
   d. Menstruation

5. Paying monthly bills (on time)

    a. Monthly bills

        (1) Rent
        (2) Gas/electric/water/sewage
        (3) Monthly and/or weekly magazine or newspaper payments
        (4) Charge card payments
        (4) Other

    b. Tips on how to cut down on monthly bills, energy conservation tips, etc.

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        (3) Making a deposit or withdrawal

    b. Checking account

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            (b) Date, check number, who the check is issued to, writing the amount of the payment, signing the check
            (c) Keeping account of written checks, how to compute the balance
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    b. Hair care
    c. Skin care
    d. Nail care
    e. Cosmetics
    f. Shaving/male and female
    g. Brushing and flossing teeth/mouthwash

2. Female physical hygiene

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    a. Keep calm
    b. Do not try to restrain the movements of the person/avoid injury
    c. Clear the area around the person/put something soft under his head
    d. Turn the person's head to the side to allow saliva or vomit to flow freely/loosen necktie or tight clothing
    e. Do not open the clenched jaws
    f. Do not give the person anything to drink
    g. Stay with the person until the seizure is over and he is fully recovered
    h. If another seizure occurs immediately after a major seizure, call a doctor
    i. For the doctor's information, note the frequency, duration and type of seizure

6. Conditions that May Increase the Frequency of Seizures

    a. Irregular use of medication
    b. Emotional stress/reactions (i.e., excitement, fear, frustration, etc.)
    c. Illness
    d. Menstruation

   e. Lack of sleep
   f. Alcohol consumption

7. When to Call the Doctor for Health Problems

   a. Severity of the symptom
   b. Persistence of the symptom
   c. Repetition of the symptom
   d. When in doubt

8. Reporting an Illness (What to Record for the Doctor)

   a. Resident's name
   b. Major complaint
   c. Fever/how high
   d. Pain/location of pain
   e. Breathing difficulty
   f. Consciousness/unconsciousness/mental confusion
   g. Other signs (i.e., bleeding, swelling, rash, etc.)
   h. Time the symptom started
   i. Remedy used (if any)

9. Supervision of Medication/Drug Maintenance

   a. Knowing why the drug is administered
   b. Knowing how and when it is given
   c. Knowing the proper dosage
   d. Possible side effects and what to do
   e. Keeping complete charts on drug maintenance of each resident

SEE DRUG CHART ON FOLLOWING PAGES

DRUG CHART

Adapted from the Life Project

DRUG	USUAL DOSAGE	ACTION	POSSIBLE SIDE EFFECTS	PRECAUTIONS
1. Anti Infectives Penicillin	Varies with disease process.	Slows growth of susceptible bacteria and frequently kills them. Probably reduces number of protective organisms usually found in bowel and in vagina.	Allergic reactions: dermatitis, hives, asthma, itching,fever shock. Super-imposed infections (diarrhea, vaginitis)	If side effects occur, antibiotic should be stopped and physician notified.
Tetracyclines Achromycin Aureomycin Terramycin	Varies with disease process.	Inhibits growth and development of wide range of pathogenic bacteria. Used in treating wide range of infections including acne, bronchitis, pneumonia, tonsillitis.	Relatively non-toxic skin rashes, nausea, vomiting, diarrhea. Vaginitis Dental staining in children whose mother took drug during pregnancy.	Do not take with milk or antacid. Report side effects to physician. Vaginitis may need to be treated with prescription drugs. Pregnant women should not take drug
Sulfonamides	Varies	Inhibits growth of susceptible bacteria. Especially effective in some types of meningitis, intestinal and urinary tract infections.	Nausea and vomiting, fever, dermatitis (rash), blood in urine.	Drink more fluids. Stop drug and call physician if side effects occur.

DRUG	USUAL DOSAGE	ACTION	POSSIBLE SIDE EFFECTS	PRECAUTIONS
Myocostatin Preparations oral tablets vaginal suppository, ointments	Varies	Antibiotic effective in treating a wide variety of yeast-like fungi infections of mouth, intestinal tract, skin, vagina.	Relatively non-toxic. Large doses by mouth may occasionally produce diarrhea. Occasionally vaginal suppositories are irritating.	Notify physician if irritation occurs.
2. Minor Tranquilizers				
Librium	Varies	Relieves anxiety and depression.	Drowsiness, confusion low blood pressure, atoxia, skin rashes, nausea, constipation.	Should not take alcohol or central nervous system drugs in combination with Librium.
Valium	Must be individualized. For adults, 2-10 mgs 2 or 3 times a day.	Used for tension and anxiety states. Relieves skeletal muscle spasms. Used with other anticonvulsant to help control petit mal and myoclonic seizures.	Drowsiness, confusion, slurred speech, double vision, atoxia, skin rash, constipation, headache.	Caution against hazardous activities that require complete mental alertness. Should not take alcohol or other drug that depresses the central nervous system.
3. Anti-Convulsants				
Dilantin	Adjusted to individual patient's needs.	Used to control major motor and psychomotor seizures.	Disturbance of equilibrium, double vision slurred speech, skin rashes, overgrowth of gum tissue, nausea and vomiting, constipation, excessive hair growth on legs and thighs.	Doses of medication must not be skipped.Upset stomach can be minimized if drugs are taken with meals. Good oral hygiene and gum massage may reduce gum overgrowth. If constipated, increase roughage and fluids in diet.

DRUG	USUAL DOSAGE	ACTION	POSSIBLE SIDE EFFECTS	PRECAUTIONS
Tridione	Adjusted to individual needs.	Used to control petit mal seizures.	Sensitivity of eyes to light, hiccups, lack of appetite.	Dark glasses if eyes are sensitive. Physician may order blood sample to be taken from time to time.
Phenobarbital	Adjusted to individual need, 32 to 100 mgs 3 times a day.	Depresses central nervous system, used for sedation and seizure control.	Drowsiness, irritability, slurred speech, unsteady gait, hyperactivity	Report side effects to physician as dosage may need to be adjusted.
4. Female Hormones Wide variety of commercial preparations available. The following is representative of an estrogen/progesterone preparation. Ovulen-21	One tablet daily for 21 days; off tablet for 7 days, the restart.	Suppresses ovulation, used to prevent pregnancy, relieve painful menstruation, reduce copious menstrual flow.	Breast tenderness, weight gain, nausea, spotty darkening of skin, headaches, blood clots.	Internal pelvic examination every 6 months including Pap Smear. If any signs of blood clots (severe leg or chest pain, difficulty in breathing, visual or speech disturbances) call physician at once and stop pill.

10. Potential Health Hazards (in and around the home)/Prevention

    a. Falls (i.e., slipping on polished or waxed floors, in bathtubs, etc.)
    b. Burns
    c. Cuts/bruises
    d. Poisoning

11. Basic First Aid

    a. Wounds/controlling bleeding
    b. Shock
    c. Artificial respiration - CPR
    d. Fractures/broken bones
    e. Seizures
    f. Burns
    g. Poisoning and antidotes
    h. Head injuries
    i. Bites (insect, animal, human)
    j. Blockage of air and food passages
    k. Drug overdose

C. Safety Management/Emergencies

1. Home Safety Tips to Avoid Accidental Fires

    a. Fire hazards in and around the home
    b. Fire prevention/facts (i.e., heat and smoke rise so stay close to the floor in emergencies, roll on the ground if clothes catch on fire, etc.)

2. Types of Fires/How to Extinguish

    a. Chemical fires
    b. Gas fires
    c. Electric fires

3. How to Store Toxic and Flammable Substances

4. Fire Drills

    a. Reporting a fire/emergency phone numbers
    b. Emergency movement routes
    c. Evacuation plans
    d. Unannounced fire drills

5. Fire Safety Regulations and Standards for Group Home Operation

D. Administrative Policies and Procedures

1. Record Keeping

    a. Admission/Discharge

(1) Applications/admission policies
(2) Intake procedures
(3) Orientation
(4) Discharge procedures

b. Individual client records

(1) Date of admission and/or discharge
(2) Birthdate
(3) Last known address
(4) Addresses and phone numbers of responsible relatives, friends and/or guardians
(5) Referral information/placement agency
(6) Needs assessment
(7) Incident reports on clients
(8) Correspondence relating to the client
(9) IPP's, progress reports, evaluations
(10) Medical, dental records/ambulatory status
(11) Physician's instructions for medication usage and disposal
(12) Authorization for emergency treatment (medical)/ consent forms
(13) Client's financial data
(14) Release forms
(15) Other

c. Incidental reports

(1) Accidents
(2) Changes in the clients' behavior/physical, mental, emotional and/or social functioning
(3) Death
(4) House budget data

d. Storage and confidentiality of client records/clients' rights

2. Administration

a. Role of the direct-care staff

(1) Day to day care of residents
(2) Meets residents' programmatic needs
(3) Self-help skills/implements IPP's
(4) Works directly with administrators, interdisciplinary team, advocates, etc.
(5) Other (i.e., mother/father image, role-model, disciplinarian, handles all types of emergencies, keeps records and charts for program matters and medication use, etc.)

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875 North Michigan Ave.
Suite 2201
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UNIT VIII

I. Community Service Model - from institutional based services to community based services (background information).

  A. Service delivery system - a network of specialized and generic service components that are directed toward meeting the general and extraordinary needs of those developmentally disabled in the population served (AC/MRDD definition, 1981).

  B. Developing a service program

  C. Obtaining access to needed services.

II. Formal/Informal Resources

  A. Formal resources - resources that are organized or have an administrative structure (i.e., church, civic clubs, etc.).

  B. Informal resources - resources contacted in a casual, unstructured fashion (i.e., family, friends, etc.).

III. Community Resources/Human Service Network

  A. Health Needs/Physical-Mental

    1. Local public health clinics, child development clinics, planned parenthood agencies, family planning clinics.

      a. Identify, evaluate and diagnose general health conditions of the residents

      b. Identify emotional and learning problems in the residents

      c. Provide referral service

    2. Mental Health Centers (i.e., MHMR)

      a. Identify, evaluate and diagnose psychological, behavioral and emotional problems

      b. Offer psychotherapy and medication, recreational activities, work activity centers, sheltered workshops, case management and advocacy

    3. Speech, hearing Clinics

      a. Assess a resident's speech and hearing problems

      b. Diagnose speech and hearing problems

      c. Prescribe corrective devises for hearing or speech

4. Vision Clinics
    a. Assess a resident's vision/examinations
    b. Diagnose visual problems
    c. Prescribe eyeglasses/contacts
5. Dental Care Clinics
    a. Identify and evaluate the dental conditions of the residents
    b. Cure dental conditions and/or perform corrective dental work
6. Emergency Health Services, Free Medical Clinics
    a. Provide emergency medical treatment on a 24-hour basis

B. Education
1. Public School System
    a. Assess the educational needs of the residents
    b. Provide special classes and training programs
2. Special Schools, Adult Educational Programs
    a. Assess the educational needs of the residents
    b. Provide special classes and activities
    c. Offer appropriate school programs
3. Technical Vocational Schools
    a. Provide technical training for future employment

C. Daily-Life Activities
1. Community Agencies, Councils, Welfare Offices, Social Service Agencies
    a. Identify and evaluate residents with special problems and/or refer them to diagnostic agencies or clinics
    b. Refer residents to the appropriate resources in the community
    c. Provide recreational programs for the residents
    d. Offer counseling services
    e. Offer financial assistance to the residents

2. Rehabilitation Centers

   a. Evaluate, identify and diagnose physical and motor problems in children and adults

   b. Provide occupational and physical therapy

   c. Recommend solutions to physical motor problems in children and adults

   d. Provide instruction and counseling services for the residents and their natural families

3. Sheltered Workshops

   a. Provide on-the-job training

   b. Help develop appropriate work attitudes

   c. Help residents find suitable employment

4. General State Rehabilitation Services

   a. Facilitate optimal vocational development and adjustment

   b. Provide job training and job placement

   c. Provide medical, vocational, and psychological diagnosis and evaluation

   d. Provide counseling and referral services

   e. Provide medical restoration services and hospitalization

   f. Provide prosthetic and orthotic devices

   g. Provide eyeglasses and visual services

   h. Provide aid for maintenance during rehabilitation

   i. Provide occupational licensing, tools, equipment, and initial stocks and supplies

   j. Offer management services for small businesses

   k. Offer interpreter services for the deaf and reader services, orientation and mobility training, daily living skills instruction, and rehabilitation teacher services for the blind.

   l. Provide transportation services

   m. Offer services to families of handicapped clients

   n. Provide follow-up services to support the client following employment

5. Recreational Services/Leisure time activities

   a. City/County Recreation Department

   b. Recreational areas within the community (i.e., parks, museums, gymnasiums, theaters, community centers, YMCA, YWCA, public swimming pools, public libraries, bowling lanes, etc.)

   c. Local church functions (i.e., dances, outings, summer church camps, etc.)

   d. City programs

      (1) Special library services

      (2) Specialized transportation (i.e., special city transit fares, wheelchair lifts, schedule on demand, etc.)

      (3) Civic center programs (i.e., ballets, symphonies, art exhibits, etc.)

      (4) Local sports organizations (i.e., special sports programs, special olympics, etc.)

      (5) Scouting troops (girls and boys)

      (6) Camp Fire organizations

   e. Leisure-time activities

      (1) Help the residents "unwind"

      (2) Provide new experiences for the residents

      (3) Help to further integrate the residents into the community

      (4) Help improve the resident's coordination

      (5) Help develop or improve social skills

      (6) Help to increase the resident's creativity

      (7) Help to create a sense of independence

6. Civic groups

   a. Offer volunteer services to the group home

   b. Donate or build equipment

        d. Provide transportation

        e. Lobby for legislation favorable to the concept of normalization

    D. Other

        1. Rehabilitation Services to the Blind or Deaf

        2. State Welfare Services

        3. State/Local Health Departments

        4. Crippled Children's Association

        5. Community Action Agencies

        6. Social Service Agencies

        7. Advocacy Groups (National and Local)

        8. Neighborhood Centers

        9. City Hall

IV. Community Relations

    A. Establishing rapport with the neighbors

        1. Holding open house to acquaint neighbors and residents

        2. Involving the neighborhood in group home activities, community involvement

        3. Organizing block parties

    B. Answering Questions

        1. What types of questions may be raised

        2. Being prepared to deal with neighbor's concerns

        3. Dispelling the myth about mental retardation

    C. Using Informal Resources

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UNIT IX

I. Advocacy

A. Types of Advocacy (discussion)

1. Legal Advocacy - litigating and legislating to establish the legal rights of people with developmental disabilities and to insure that those rights are not violated.

2. Systems Advocacy - influencing social and political systems to bring about changes in laws, rules, regulations, policies, and practices for the benefit of groups of people (i.e., establishing group homes when there have been none established, arranging for for removal of architectural and transportation barriers, provide consultation and legal representation in courts on zoning hearings and other legal matters, etc.).

3. Citizen Advocacy - a program matching mature, competent volunteers in one-to-one relationships with people who are developmentally disabled. Such advocates represent the rights and interests of residents (i.e., citizen advocate-protege relationship).

4. Self Advocacy - acting in one's own behalf.

5. Protection and Advocacy (P&A systems) - the state agencies mandated by Section 113 of the Developmental Disabilities Act and Bill of Rights Act to provide a broad range of protection and advocacy services (i.e., such a system has the authority to pursue legal, administrative and other appropriate remedies to insure the protection of the residents' rights).

B. Organizational Structure

1. Internal Advocacy - supported by the facility.

2. External advocacy - supported by sources outside the service system.

II. Advocates

A. Types - people who are developmentally disabled, parents, staff and administrators, professionals, and volunteers (i.e., lawyers, social scientists, reporters, lobbyists, elected officials, etc.).

B. What Advocates Can Do/Goals

1. Assure the quality of residential programming and facilities.

2. Help develop comprehensive residential services.

3. Help develop community support services.

4. Meet the residents' basic human need to be cared for while providing guidance.
5. Help families through deinstitutionalization.
6. Provide case finding and referral services.
7. Do case management and follow-along.
8. Teach self-advocacy and community living skills.
9. Represent individuals or groups in legal matters.
10. Provide protective services.
11. Educate the public.
12. Other.

III. Residents' Rights

A. Sources of Legal Rights

1. The Due Process Clause of the Fourteenth Amendment.
2. The Equal Protection Clause of the Fourteenth Amendment.
3. Rights to Privacy (i.e., applies to matters of marriage, protection, contraception, family relationships, child rearing and education, abortion, sterilization, etc.).
4. Section 504 of the Rehabilitation Act of 1973.
5. The Developmental Disabilities Assistance and Bill of Rights Act.

B. Basic Rights

1. The right to liberty.
2. Procedural due process.
3. The right to least restrictive alternatives.
4. The right to treatment and habilitation services.
5. The right to individualized program plans.
6. Freedom from harm and abuse.
7. The right to a humane and safe environment.
8. The right to an equal education.

9. Confidentiality and access of records.

10. Sexual, marital, and parental rights.

11. Equal access to medical services.

12. The right to advocacy services and legal access.

13. The right to vote.

14. Others (i.e., the right to send and receive mail, the right to choose and practice religion, the right to enter into contracts and to own and dispose of property, etc.).

IV. Legal Recourse/Where to go for Information and Legal Aid

A. Legal aid offices or legal services

B. State protection and advocacy offices for developmental disabilities

C. Legal aid clinics attached to law schools

D. American Civil Liberties Union

E. Local offices of the Bar Association

F. Local offices of the Association for Retarded Citizens

G. Private lawyers

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Scheerenberger, R. C. *Managing residential facilities for the developmentally disabled*. Springfield, IL: Charles C. Thomas Publisher, 1975.

Schwartz, B. *The fourteenth amendment*. New York: New York University Press, 1970.

Seitel, F. P. *The practice of public relations*. Columbus, OH: Charles E. Merrill Publishing Co., 1980.

Sigelman, C. K. Group homes for the mentally retarded. Lubbock, TX: Research and Training Center in Mental Retardation, 1973.

Singletary, E. E., Collins, G. D. & Dennis, H. F. Law briefs on litigation and the rights of exceptional children, youth, and adults. Washington, D. C.: University Press of America, 1977.

Sitkei, E. G. Systematic planning and programming for group homes and an approach to accountability for group home operation. Oregon: Rehabilitation Research and Training Center in Mental Retardation, 1976.

Smith, C. B. & Anderson, K. E. Training for residential alternatives. Columbus, OH: The Ohio Developmental Disabilities Planning Council.

Standards for services for developmentally disabled individuals. Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons. Washington, D. C.: AC/MRDD, 1981.

Stripling, T. & Ames, S. J. Intermediate care facilities for the mentally retarded. Federal Information and Assistance Project. Washington, D. C.: GPO, 1977 (draft).

Swadron, B. B. Mental retardation - the law - guardianship. Toronto: National Institute on Mental Retardation.

Texas state plan for the development of community based residential services for mentally retarded citizens. Austin, TX: The Texas Association for Retarded Citizens, 1980.

The estimated cost of accessible buildings. Washington, D. C.: Department of Housing and Urban Development, Office of Policy Development and Research, 1979.

The life project. Living in a family environment: A training program for group home parents. Madison, WI: The Harry A. Waisman Center on Mental Retardation and Human Development, 1976.

Thompson, M. M. Housing for the handicapped and disabled: A guide for local action. Washington, D. C.: The National Association of Housing and Redevelopment Officials, 1977.

Training for independent living. California: Ventura County Association for the Retarded, Inc., 1978.

Walls, R. T. et al. The independent living behavior checklist. Dunbar, WV: West Virginia Research and Training Center, 1979.

Warren, F. & Hatton, M. Health services programs. Federal Programs Information and Assistance Project. Washington, D. C.: GPO, 1979 (draft).

Warren, F. Organizational planning for action. Federal Programs Information and Assistance Project. Washington, D. C.: GPO, 1978 (draft).

Wood, V. Due process of law. Baton Rouge, LA: Louisiana State University Press, 1951.

Young, J. (Ed.) Privacy. New York: John Wiley & Sons, 1978.

Zamarripa, S. J. An orientation manual to the independent group residence. Atlanta, GA: Georgia Department of Human Resources, 1980.

APPENDIX A

ANNOTATED BIBLIOGRAPHY

Community Living/Establishing and Operating Residential Facilities

Braddock, D. Opening Closed Doors. (VA: The Council for Exceptional Children, 1977).

This book surveys current trends and issues pertaining to deinstitutionalization in America. It reviews ideological, public policy, psychosocial and programmatic issues. It also includes a comprehensive annotated bibliography on material relevant to independent living.

Write: The Council for Exceptional Children
Publications Sales
1920 Association Drive
Reston, VA 22091

Bright, M. Planning Residential Alternatives. (Austin, TX: Texas Association for Retarded Citizens, 1981).

This manual is a useful guide developed in the state of Texas for planning and funding community-based residential facilities for the developmentally disabled. It includes information on general guidelines for the planning process, funding sources, and resource materials, agencies, and organizations.

Write: Mike Bright
Texas Association for Retarded Citizens
833 Houston Street
Austin, TX 78756

Bruininks, R. H. et al. Deinstitutionalization and Community Adjustment of Mentally Retarded People. (Washington, D. C.: AAMD, 1981).

This monograph (no. 4) combines two sets of papers developed around the general issues of deinstitutionalization and adjustment of mentally retarded people living in community settings. The papers present a broad, in-depth examination of deinstitutionalization as a public policy, its trends and special problems in implementation, conceptual and methodological aspects of its study.

Write: American Association on Mental Deficiency
5101 Wisconsin Avenue, N.W.
Washington, D. C. 20016

Community Residential Options. (Arlington, VA: The Sheltered Occupational Center of Northern Virginia, Inc., 1975).

The manual is based on the Northern Virginia experience in group homes. It is useful as a guide on program planning and development for groups who want to start up a residential program. The information contained within the manual includes funding and funding sources, an overview of implementing a residential program, program and resident evaluation, client rights, advocacy, community resources utilized by group homes, and management systems.

Write: Northern Virginia Association for Retarded Citizens, Inc.
Suite 200-A
105 East Annandale Road
Falls Chirch, VA 22046

Frieden, L. et al. ILRU Source Book: A Technical Assistance Manual on Independent Living. (Houston, TX: The Institute for Rehabilitation and Research, 1979).

This book has been compiled as a means of sharing previous experiences in independent living with persons, organizations, and communities that are beginning to become involved in this field. It is designed to assist in defining important issues in planning an independent living project and serve as a source of ideas that can be adapted in a variety of community contexts.

Write: The Independent Living Research Utilization Project
P.O. Box 20095
Houston, TX 77025

Gage, M. A. et al. Group Homes for the Developmentally Disabled Children. (Oregon: Instructional Development Corporation, 1977).

This book describes the experiences of two experimental group homes for developmentally disabled children. It includes descriptions of the homes and children served, the relationship between the school and group home, suggestions for starting a group home, ways to obtain suitable candidates for the home, results with children, costs of the home, and a plan for a community.

Write: Instructional Development Corporation
P.O. Box 361
Mammouth, OR 97361

Goodfellow, R. Group Homes: One Alternative. (Syracuse, NY: Human Policy Press, 1974).

This booklet shares the experiences of administrators, houseparents, residents, and friends involved in the group home movement.

Write: Human Policy Press
P.O. Box 127
University Station
Syracuse, NY 13210

Kugel, R. and Shearer, A. (Eds.) *Changing Patterns in Residential Services for the Mentally Retarded*. (Washington, D. C.: GPO, 1976).

This manuscript is an updated report on residential facilities for mentally retarded persons. It stresses the normalization principle and describes various models of residential facilities in the United States and abroad.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Lawder, E. A.; Andrews, R. G.; and Parsons, J. R. *Five Models of Foster Family Group Homes*. (New York: Child Welfare League of America, Inc. 1974).

This monograph describes five foster family models useful in putting the concept of differentiated foster family care into practice.

Write: Child Welfare League of America, Inc.
67 Irving Place
New York, NY 10003

Mambort, T. T. et al. *Community Acceptance: A Realistic Approach*. (Ohio: Montgomery County Board of Mental Retardation and Developmental Disabilities, 1981).

This report delineates the results of a county-wide neighborhood opinion survey and a property sales study regarding the effects of family group homes for the developmentally disabled. The study took place in Montgomery County, Ohio.

Write: Montgomery County Board of Mental Retardation
8114 N. Main Street
Dayton, OH 45415

Mamula, R. A. and Newman, M. S. W. *Community Placement of the Mentally Retarded*. (Springfield, IL: Charles C. Thomas Publisher, 1973).

The book examines the basic components of the community placement concept, discusses its historical development, and offers guidelines for the development of effective community placement programs designed to meet the particular requirements of the individual communities and agencies involved.

Write: Charles C. Thomas Publisher
301-327 East Lawrence Avenue
Springfield, IL 62717

O'Connor, G. *Home Is A Good Place*. (Washington, D. C.: American Association on Mental Deficiency, Inc., 1976).

This monograph (no. 2) discusses the national perspective of community residential facilities for developmentally disabled persons. It includes discussions of community residential facilities, the establishment of facilities, and community services and characteristics of residents.

Write: American Association on Mental Deficiency
5101 Wisconsin Avenue, N.W.
Washington, D. C. 20016

People Live In Houses: Profiles of Community Residences for Retarded Children and Adults. (Washington, D. C.: GPO, 1975).

This booklet describes group homes, foster homes, and independent residential facilities as alternatives to the institutionalization of the mentally retarded.

Write: President's Committee on Mental Retardation
Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Scheerenberger, R. C. Managing Residential Facilities for the Developmentally Disabled. (Springfield, IL: Charles C. Thomas Publisher, 1975).

This book serves as an introduction to some of the broader aspects of managing a group home. Primary attention is devoted to philosophy, personnel, organization, leadership, planning and evaluation, and organized labor.

Write: Charles C. Thomas Publisher
301-327 East Lawrence Avenue
Springfield, IL 62717

Sigelman, C. K. Group Homes for the Mentally Retarded. (Lubbock, TX: R&T Center in Mental Retardation, 1973).

This monograph examines the potential of group homes coordinated by both mental retardation and vocational rehabilitation agencies. Issues covered include the need for a degree of support and supervision in the community for those mentally retarded persons living independently, and the role of vocational rehabilitators in finding and helping the individual maintain a job.

Write: Research and Training Center in Mental Retardation
Texas Tech University
Box 4510
Lubbock, TX 79409

Sitkei, E. G. Systematic Planning and Programming for Group Homes and an Approach to Accountability for Group Home Operation. (Oregon: Rehabilitation Research and Training Center in Mental Retardation, 1976).

These reports provide information on the systematic management of the daily operation of the community residential facility. Included in the report is material on program budgets, elements of systematic planning for program development, and how to write and implement goals and objectives.

Write: Rehabilitation Research and Training Center in Mental Retardation
2nd Floor, Clinical Services Building
University of Oregon
Eugene, OR 97403

Zamarripa, S. J. An Orientation Manual to the Independent Group Residence. (Atlanta, GA: Georgia Department of Human Resources, 1980).

This document was developed to provide service workers with a manual from which to plan, develop, and operate an independent group residence. Based on a Community Residential Service Model, the manual contains information about the purpose of the model, its costs, and funding base. For the developer and manager, information is included on optimal housing designs, staff arrangements, staff roles, personnel, various functions within the home, and scheduling arrangements.

Write: Sam J. Zamarripa
Mental Health and Mental Retardation
47 Trinity Avenue, S.W.
Atlanta, GA 30034

Staff/Training Manuals

A Better Answer...Supervision In Home Care: A Training Manual for Supervisors and A Training Guide for Instructors. (New York: National HomeCaring Council, Inc., 1982).

The training guide is the companion piece to the basic manual for supervisors. This guide is designed as a resource to the trainer to assist in effective supervisory training program development, utilization of the content of the curriculum found in the manual, and presentation of the materials, exercises, and aids. The guide contains selected activities which can be integrated into the content of the training sessions, and it parallels the manual. Structured activities, case studies, exhibits, handouts, role plays, visual aids, and discussion questions are given in the training guide.

Write: National HomeCaring Council, Inc.
235 Park Avenue, South
New York, NY 10003

Bensberg, G. J. and Barnett, C. D. Attendant Training in Southern Residential Facilities for the Mentally Retarded. (Atlanta, GA: Southern Regional Education Board, 1966).

This report includes an account of a five year project sponsored by the Southern Regional Educational Board and the National Institute of Mental Health on the role of the attendant, the development of a training curriculum, in-service training of personnel responsible for curriculum development and teaching attendants, and evaluation of training programs of various operating institutions for the mentally retarded. The report also sets guidelines based on experience for persons who are responsible for setting up or conducting attendant training programs in institutions for the mentally retarded.

Write: Southern Regional Education Board
130 Sixth Street, N.W.
Atlanta, GA 30313

Cox, B. I Can Do It. I Can Do It. (Series) (Newport Beach, CA: K&H Publishing, 1981).

The I Can Do It. I Can Do It. Series for People With Very Special Needs is a set of learning and teaching books for the mentally retarded in daily living skills. The series covers physical exercise, cooking, housekeeping, personal grooming and physical hygiene, and day-to-day purchasing of items in a consumer guide.

Write: K&H Publishing Company
3300 West Pacific Coast Highway, Suite F
Newport Beach, CA 92663

Group Home Staff Training: A Trainer's Manual. (Tallahassee, FL: Florida Association of Rehabilitation Facilities, Inc., 1977).

This training program is designed to provide group home staff with a comprehensive introduction to the basic skills and information needed in the operation of a group home. Active participation among the trainees ensures that the information provided is meaningful and that learning is occurring.

Write: Florida Association of Rehabilitation Facilities, Inc.
347 Office Plaza
Tallahassee, FL 32301

Lakin, K. C. and Bruininks, R. H. Occupational Stability of Direct-Care Staff of Residential Facilities for Mentally Retarded People. (Minneapolis, MN: Department of Psychoeducational Studies, University of Minnesota, 1981).

This study was based on a national sample of residential facilities for retarded people and of the staff employed in them. The major study was comprised of three substudies: (1) data collected from 71 public facilities and 137 non-public facilities regarding crude annual turnover rates and related organizational variables; (2) a one-month, complete listing of all direct-care staff separating from 75 public and 161 non-public facilities including personal data and reasons for separation; and (3) a one-year follow-up survey of 1002 interviewed direct-care personnel of sampled public and non-public facilities.

Write: Development Disabilities Project on Residential Services and Community Adjustment
207 Pattee Hall
150 Pillsbury Drive, S.E.
Minneapolis, MN 55455

McCarthy, T. J. Managing Group Homes: A Training Manual. (Nashville, TN: Tennessee Department of Mental Health and Mental Retardation, 1980).

This training manual is designed to train the home manager in areas such as nutrition, human behavior, and mental health law. It consists of a self-study unit, tests and grades, and on-the-job training projects aimed at helping the home manager gain greater satisfaction from the job.

Write: Terrence J. McCarthy
P.O. Box 140496
Nashville, TN 37214

Provencal, G. and Evans, D. Resident Manager Education: A Curriculum Model for Educating Foster Parents and Group Home Personnel. (Mt. Clemens, MI: Macomb-Oakland Regional Center, 1977).

This curriculum model combines education and training in areas such as an orientation to mental retardation, maintaining healthy environments, providing emergency care, fire and safety considerations, administrative responsibilities, and other areas dealing with independent living for the developmentally disabled.

Write: Macomb-Oakland Regional Center
16200 Nineteen Mile Road
Mt. Clemens, MI 48044

Rizzo, D. C. et al. Manual for the Instruction of Operators for the Mentally Retarded of Family Care Homes. (Trenton, NJ: New Jersey Department of Human Services, 1978).

This manual is used for training those individuals who are providing care for mentally retarded adults in their homes and larger group homes. The manual is divided into six sections or chapters. The objectives of the training are to better acquaint the trainees with the needs of their residents, to normalize the lives of the adults placed in facilities, and to better integrate them into the mainstream of the community.

Write: New Jersey Department of Human Services
Division of Mental Retardation
Bureau of Field Services
169 W. Hanover Street
Trenton, NJ 08618

Rosen, H. S. et al. Teaching Community Residential Staff: Competencies, Procedures, and Outcomes. (Akron, OH: Blick Clinic for Developmental Disabilities, Inc., 1981).

This manual examines three basic components of a data collection system used to evaluate the effectiveness of a residential training program: Observational Data, Survey Data, and Training Data.

Write: Blick Clinic for Developmental Disabilities, Inc.
640 W. Market Street
Akron, OH 44303

Smith, C. B. and Anderson, K. E. *Training for Residential Alternatives*. (Columbus, OH: The Ohio Developmental Disabilities Planning Council).

The manual contains an outline of core content areas for training in residential alternatives. Also included in the manual are: (1) a technique for analyzing the effectiveness of these questions in evaluating training sessions, (2) recommendations for future development of multiple-choice questions, and (3) a description of a filing system for the development of a resource pool of items.

Write: The Nisonger Center for Mental Retardation
and Developmental Disabilities
Ohio State University
Columbus, OH 43210

The Life Project. Living In A Family Environment: A Training Program for Group Home Parents. (Madison, WI: The Harry A. Waisman Center on Mental Retardation and Human Development, 1976).

This is a program to train group home parents to assist mentally retarded adults in becoming more independent. The kit contains 2 film strips, 10 audio cassettes, and 8 manuals. The manuals are designed to teach the group home parents, but also offer suggestions on instructing residents in hygiene, recreation, social behavior, leisure time, and sexuality.

Write: Omega Films Ltd.
133 Manville Road
Unit 19
Scarborough, Ontario

Training for Independent Living. (California: Ventura County Association for the Retarded, Inc., 1978).

This manual describes a program designed to teach handicapped adults the skills they need for living independently in the community. TIL is designed as a transitional living situation. Persons enter the program, learn the skills, and move out into their own apartments. The material is divided into three parts: Part 1 is a discussion of program decisions such as where to locate, what staff is needed, how to divide the trainee's time, how to evaluate training progress; Part 2 consists of lesson plans for 149 separate teaching objectives; Part 3 is an appendix which gives some specific procedures which are used at TIL.

Write: Ventura County Association for the Retarded, Inc.
P.O. Box 646
Camarillo, CA 93010

Walls, R. T. et al. The Independent Living Behavior Checklist. (Dunbar, WV: West Virginia Research and Training Center, 1979).

This checklist is about independent living skills, what they are, and how they can be measured. The skill objectives are presented as clearly stated conditions, behaviors, and standards. The areas covered include mobility, self-care (dressing, clothing care, hygiene), home maintenance and safety, nutrition and food preparation, interpersonal relations, telephone use, functional reading and writing, and money management.

Write: West Virginia Research and Training Center
Administration, Training and Publications Staff
1223 Myers Avenue
Dunbar, WV 25064

Housing/Structural Design/Accessibility

A Guidebook To: The Minimum Federal Guidelines & Requirements for Accessible Design. (Washington, D. C.: U.S. Architectural & Transportation Barriers Compliance Board, 1981).

This book contains the guidelines and requirements for the issuance of consistent and improved accessibility and usability standards issued by the General Services Administration, Department of Housing and Urban Development, Department of Defense, and the U.S. Postal Service, under the Architectural Barriers Act of 1968, as amended. These guidelines and requirements are in a format more readily usable by state and local building officials and federal building managers.

Write: Office of Technical Services
U.S. Architectural and Transportation
Barriers Compliance Board
Washington, D. C. 20202

Adaptable Dwellings. (HUD: Office of Policy Development & Research, 1979).

This report outlines how adaptive devices and architectural/interior design features can be used to make a home accessible for the physically handicapped. A study of consumer acceptance of design features is presented, along with recommendations for an approach to the design of dwellings.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

An Evaluation of Housing for the Severely Disabled: In the Context of a Service Delivery System. (HUD: Office of Policy Development and Research, 1976).

This report describes the philosophy, approach, and findings of a post occupancy evaluation of Creative Living, an 18-unit apartment complex in Columbus, Ohio. The apartment units are specifically designed for quadriplegic residents.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Handbook for Design: Specially Adapted Housing. (Veteran's Administration, 1978).

This pamphlet provides information on housing designs and features that make homes more accessible to the physically disabled. The information is presented in such a manner as to increase the architect's or designer's sensitivity to the housing needs of the physically handicapped through specific design details.

Write: Veterans Administration
Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

The Estimated Cost of Accessible Buildings. (HUD: Office of Policy Development and Research, 1979).

This report assesses the construction costs for the renovation of existing buildings and the cost of redesigning new buildings for the handicapped. The estimated costs include construction costs, labor, materials, delivery costs, and profit margins for making various types of buildings barrier-free.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Thompson, M. M. Housing for the Handicapped and Disabled: A Guide for Local Action. (Washington, D. C.: The National Association of Housing and Redevelopment Officials, 1977).

This book offers basic information and guidance that local groups can use to develop residential living environments, incorporating special design and service components. It is a step-by-step guide that treats each aspect of the housing development process as it will most likely be encountered by any local group conceiving and undertaking housing for handicapped persons.

Write: The National Association of Housing and Redevelopment Officials
2600 Virginia Avenue, N.W.
Washington, D. C.20037

Policies/Procedures/Standards

Gibson, W. M. (Director) Operating Manual for Residential Services Personnel. (Columbus, OH: The Nisonger Center for Mental Retardation and Developmental Disabilities, 1974).

The book contains a collection of individually written articles concerning a variety of topics as they relate to residential operation and administration. The book is divided into three broad areas. Part 1 is basically for administrators on the overall operation of the Group Home. Part 2 is aimed at the residential services personnel and provides basic information and programming for residents. Part 3 deals with emergency procedures.

Write: The Nisonger Center for Mental Retardation and Developmental
Disabilities
1580 Cannon Drive
Columbus, OH 43210

Interpretive Guidelines and Survey Procedures for the Application of the Standards for Institutions for the Mentally Retarded or Persons with Related Conditions. (Federal Register, 1977).

Federal standards for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are delineated as they pertain to those facilities that receive federal Medicaid funds for health or habilitative services. The standards are necessary to assure high quality services for the development of maximum independent living capabilities of the residents. Facilities receiving ICR/MR reimbursement must rigorously conform to these standards as they relate to health and safety codes. The standards take into account the widely diverse needs of the mentally retarded.

Intermediate Care Facilities for the Mentally Retarded. (Federal Programs Information and Assistance Project, Washington, D. C.: GPO).

The text is set up as a training module to provide a basic understanding of the ICF/MR process and services. The manual also includes an overview of Medicaid and funding mechanisms for ICF/MR's.

Write: Federal Programs Information and Assistance Project
1522 K. Street, N.W.
Washington, D. C. 20005

Standards for Services for Developmentally Disabled Individuals. Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons. (Washington, D. C.: AC/MRDD, 1981).

The document delineates the standards of operation for the accreditation of residential facilities that house persons with developmental disabilities. The accreditation process sets the standards for residential services. These standards are used to assess residential program operation. A Survey Questionnaire guide is available for use with the AC/MRDD standards document. The questionnaire is necessary in reporting to the Accreditation Council the self-survey that is required of each facility seeking accreditation by the Council.

Write: AC/MRDD
5101 Wisconsin Avenue, N.W.
Washington, D. C. 20016

Fire Safety

National Bureau of Standards. *Fire and Life Safety for the Handicapped*. (Washington, D. C.: GPO, 1980).

This report contains information obtained from The Conference on Fire Safety for the Handicapped held at the National Bureau of Standards, November 26-27, 1979, and from the Workshop on Life Safety for the Handicapped held in Washington, D. C., and Sacramento, California, August and September 1979. It is designed as a comprehensive and basic source documented in the area of fire and life safety for the handicapped.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

National Fire Protection Association. *Life Safety Code*. (Quincy, MA: National Fire Protection Association, Inc., 1981, revised).

The Life Safety Code lists minimum requirements that were adopted to create a reasonable degree of safety from fire in buildings and structures. The Code addresses those construction, protection, and occupancy features necessary to minimize danger to life from fire, smoke, fumes, or panic. Buildings are divided into classifications of occupancy and regulations are recorded in accordance to the building classification.

Write: National Fire Protection Association
ATTN: Publications Sales Division
Batterymarch Park
Quincy, MA 02269

Nelson, H. E. and Shibe, A. J. *A System for Fire Safety Evaluation of Health Care Facilities*. (Washington, D. C.: Center for Fire Research, 1978).

This report is part of a 5-year fire safety program which consists of information and projects on decision analysis, fire and smoke detection, smoke movement and control, automatic extinguishment, and behavior in institutional populations in fire situations. The report consists of a methodology for generating an equivalency system for a specific fire safety requirement and a specific example for a system which provides equivalency to the minimum life safety requirements for health care facilities.

Write: Center for Fire Research
National Engineering Laboratory
National Bureau of Standards
U.S. Department of Commerce
Washington, D. C. 20234

Ramey-Smith, A. M. Group Homes for the Developmentally Disabled: Case Histories of Demographics, Household Activities and Room Use. (Washington, D. C.: Rehabilitation Services Administration, Office of Human Development Services, 1979).

This study was developed to provide data necessary for the development of life safety codes appropriate for group homes. Data are presented for room use and activities of developmentally disabled residents. Recommendations are presented regarding fire safety for group homes.

Write: Consumer Sciences Division
Center for Consumer Product Technology
National Bureau of Standards
Washington, D. C. 20234

Legal

Allen, R. C. Legal Rights of the Disabled and Disadvantaged. (Washington, D. C.: GPO, 1969).

One of a series of five papers prepared for the use of delegates to the National Citizens Conference on the Disabled and Disadvantaged held June 24-27, 1969, in Washington, D. C. The paper deals with legal matters that affect the disabled.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Baucom, L. et al. Action through Advocacy. (Lubbock, TX: Research and Training Center in Mental Retardation, 1980).

This manual is useful for training volunteers in state protection and advocacy agencies. It is set up as a curriculum to train volunteer advocates who have direct relationships with developmentally disabled people. The broad goal of the training is to give volunteer advocates knowledge of developmental disabilities and of the advocate's role, an understanding of the attitudes that affect the lives of developmentally disabled persons and basic skills in communication, assertiveness, and taking action for change.

Write: Research and Training Center in Mental Retardation
Texas Tech University
Box 4510
Lubbock, TX 79409

Baucom, L. et al. Citizen Advocacy: How to Make It Happen. (Lubbock, TX: Research and Training Center in Mental Retardation, 1980).

This text discusses the foundations of citizen advocacy and how to set up and administer a citizen advocacy program. It further discusses the functions of such a program. The information is presented in three parts. Part 1 gives an overview of citizen advocach and tells how to assess community support, find a sponsor, incorporate, form a board, seek funds, hire staff, and select an office site. Part 2 provides tips on essential management functions. Part 3 discusses the program functions that are most critical for advocacy such as recruiting volunteers, screening and matching advocates and proteges, training, and follow-up.

Write: Research and Training Center in Mental Retardation
Texas Tech University
Box 4510
Lubbock, TX 79409

Baucom, L. D. and Bensberg, G. J. Advocacy Systems for Persons with Developmental Disabilities. (Lubbock, TX: Vintage Press, 1977).

This volume consists of presentations on the context of advocacy, components of comprehensive advocacy systems, and resources for assistance presented at national conferences sponsored jointly by the Developmental Disabilities Office of the Office of Human Development and the Research and Training Center in Mental Retardation of Texas Tech University. The combined proceedings and five issue papers are contained within this text.

Write: Research and Training Center in Mental Retardation
Texas Tech University
Box 4510
Lubbock, TX 79409

Herr, S. S. From Rights to Realities: Advocacy By and For Retarded People in the 1980's. (Washington, D. C.: GPO, 1979).

The author's views of the rights of the handicapped are discussed with particular attention to future implications including priority setting and resources for legal advocacy.

Write: Superintendent of Documents
U.S. Government Printing Office
Washington, D. C. 20402

Lauber, D. Zoning for Family and Group Care Facilities. (Chicago, IL: Planning Advisory Committee, 1974).

This report deals with issues related to zoning practices dealing with residential facilities in communities including regulatory obstacles, community pressure, and recommended zoning treatment. The zoning process is dealt with in regard to guidelines and legislation affecting zoning ordinances.

Write: American Society of Planning Officials
1313 East Sixtieth Street
Chicago, IL 60637

Rude, C. D. and Aiken, P. A. Advocacy in Residential Programs. (Lubbock, TX: Research and Training Center in Mental Retardation, 1982).

This book presents information that applies specifically to residential programs for the handicapped such as the various types, aims, and procedures of residential programs and about relevant rights and standards. It is intended as a training guide for advocates for people in residential programs and can apply to various types of advocacy programs, including self-advocacy, citizen advocacy, systems advocacy, and legal advocacy.

Write: Research and Training Center in Mental Retardation
Texas Tech University
Box 4510
Lubbock, TX 79409

Singletary, E. E.; Collins, G. D. and Dennis, H. F. Law Briefs on Litigation and the Rights of Exceptional Children, Youth, and Adults. (Washington, D. C.: University Press of America, 1977).

The text deals with legal information drawn from cases, law material, professional texts, journals, and law reviews on legal issues that affect the handicapped. Particular attention is given to landmark cases involving the handicapped person's rights (i.e., education, treatment, voting, etc.).

Write: University Press of America
4710 Auth Place, S.E.
Washington, D. C. 20023

Swadron, B. B. Mental Retardation - The Law - Guardianship. (Toronto: National Institute on Mental Retardation).

The text deals with a broad range of legal issues involving the rights of the mentally retarded including such issues as marriage, parenthood, mandatory employment laws, child protection laws, guardianship, citizen advocacy, etc. The text brings together available knowledge and experience in the field of mental retardation as a foundation for action and implementation of new or existing legislation, services, and practices.

Write: National Institute on Mental Retardation
York University Campus
4700 Keele Street
Downsview, Toronto
Canada

APPENDIX B

LIFE SAFETY CODE

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CHAPTER 13 EXISTING HEALTH CARE OCCUPANCIES

SECTION 13-1 GENERAL REQUIREMENTS

13-1.1 Application

13-1.1.1 General

13-1.1.1.1 Existing health care facilities shall comply with the provisions of this chapter. (See Chapter 31 for operating features.)

Exception: Hospitals and nursing homes found to have equivalent safety. One such method for determining this equivalency is given in Appendix C.

13-1.1.1.2 This chapter establishes life safety requirements for the design of all existing hospitals, nursing homes, residential-custodial care and supervisory care facilities. Where requirements vary, the specific occupancy is named in the paragraph pertaining thereto. Section 13-6 establishes life safety requirements for the design of all existing ambulatory health care centers.

13-1.1.1.3 Health care occupancies are those used for purposes such as medical or other treatment or care of persons suffering from physical or mental illness, disease or infirmity; for the care of infants, convalescents or infirm aged persons.

13.1.1.1.4 Health care facilities provide sleeping accomodations for the occupants and are occupied by persons who are mostly incapable of self-preservation because of age, physical or mental disability, or because of security measures not under the occupants' control.

13-1.1.1.5 This chapter also covers ambulatory health care centers as defined in 13-1.3(e). See Section 13-6 for requirements.

13-1.1.1.6 Buildings or sections of buildings which house, or in which care is rendered to, mental patients, including the mentally retarded, who are capable of judgment and appropriate physical action for self-preservation under emergency conditions in the opinion of the governing body of the facility and the governmental agency having jurisdiction, may come under other chapters of the *Code* instead of Chapter 13.

13-1.1.1.7 It shall be recognized that, in buildings housing certain types of patients or having detention rooms or a security section, it may be necessary to lock doors and bar windows to confine and protect building inhabitants. In such instances, the authority having jurisdiction shall make appropriate modifications to those sections of this *Code* which would otherwise require the keeping of exits unlocked.

13.1.1.1.8 It shall be also recognized that some mental health patients are not capable of seeking safety without guidance.

13-1.1.1.9 Buildings or sections of buildings which house older persons and which provide activities that foster continued independence but do not include those services distinctive to residential-custodial care facilities [as defined in 13-1.3 (c)] shall be subject to the requirements of other Sections of this *Code*, such as Chapter 19.

13.1.1.1.10 Health care occupancies shall include all buildings or parts thereof with occupancy as described in this chapter under Special Definitions, 13-1.3.

13-1.1.2 Objective. The objective of this chapter is to provide a reasonable level of safety by reducing the probability of injury and loss of life from the effects of fire with due consideration for functional requirements. This is accomplished by limiting the development and spread of a fire emergency to the room of fire origin and reducing the need for occupancy evacuation, except from the room of fire origin.

13-1.1.3 Total Concept. All health care facilities shall be so designed, constructed, maintained, and operated as to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be assured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and careful development of operating and maintenance procedures composed of the following:

(a) Proper design, construction, and compartmentation;
(b) Provision for detection, alarm, and extinguishment; and
(c) Fire prevention and the planning, training, and drilling in programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building.

13-1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations.

13-1.1.4.1 Additions shall be separate from any existing structure not conforming to the provisions within Chapter 13 by a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition.

13-1.1.4.2 Communicating openings in dividing fire barriers required by 13-1.1.4.1 shall occur only in corridors and shall be protected by approved self-closing fire doors. (See also Section 6-2.)

13-1.1.4.3 Doors in barriers required by 13-1.1.4.1 shall normally be kept closed.

Exception: Doors may be held open only if they meet the requirements of 13-2.11.5.

13-1.1.4.4 Conversions. An existing building may be converted to a hospital, nursing home, or residential-custodial care facility only if it complies with all requirements for new health care buildings prior to occupancy as a health care facility. (See Chapter 12.)

13-1.1.4.5 Modernization or Renovation. Alterations shall not diminish the level of life safety below that which exists prior to the alterations except that life safety features in excess of those required for new construction are not required to be maintained. In no case shall the resulting life safety be less than that required for existing buildings. Alterations or installations of new building services equipment shall be accomplished as nearly as possible in conformance with the requirements for new construction.

13-1.1.4.6 Construction Operations. See 1-6.3 and Chapter 31 for life safety provisions during construction.

13-1.1.5 Modification of Retroactive Provisions.

13-1.1.5.1 The requirements of this section may be modified if their application clearly would be impractical in the judgement of the authority having jurisdiction and if the resulting arrangement could be considered as presenting minimum hazard to the life safety of the occupants. The requirements may be modified by the authority having jurisdiction to allow alternative arrangements that will secure as nearly equivalent safety to life from fire as practical; but in no case shall the modification afford less safety than compliance with the corresponding provisions contained in the following part of this *Code*.

13-1.1.5.2 A limited but reasonable time shall be allowed for compliance with any part of this section, commensurate with the magnitude of expenditure and the disruption of services.

13-1.1.5.3 Alternative protection, installed and accepted, shall be considered as conforming for purposes of this *Code*.

13-1.2 Mixed Occupancies.

13-1.2.1 Sections of health care facilities may be classified as other occupancies if they meet all of the following conditions:

(a) They are not intended to serve health care occupants for purposes of housing, treatment or customary access.

(b) They are adequately separated from areas of health care occupancies by construction having a fire resistance rating of at least 2 hours.

13-1.2.2 Ambulatory care (see Section 13-6), medical clinics and similar facilities which are contiguous to health care occupancies but are primarily intended to provide outpatient services may be classified as a business or ambulatory care occupancy provided the facilities are separated from health care occupancies by not less than 2-hour fire-resistive construction.

Exception: When the business occupancy or similar facility is intended to provide:

(a) Services for hospital patients who are litter borne, or,
(b) General anesthesia services,

the section shall meet all requirements for health care facilities.

13-1.2.3 Health care occupancies in buildings housing other occupancies shall be completely separated from them by construction having fire resistance rating of at least 2-hours; as provided for additions in 13.1.1.4.

13.1.2.4 All means of egress from health care occupancies that traverse non-health care spaces shall conform to requirements of this *Code* for health occupancies.

Exception: It is permissible to exit through a horizontal exit into other contiguous occupancies which do not conform with health care egress provisions but which do comply with requirements set forth in the appropriate occupancy chapter of this *Code*, as long as the occupancy does not have high hazard contents. The horizontal exit must comply with the requirements of 13-2.2.5.

13-1.2.5 Auditoriums, chapels, staff residential areas or other occupancies provided in connection with health care facilities shall have exits provided in accordance with other applicable sections of the *Code*.

13.1.2.6 Any area with a hazard of contents classified higher than that of the health care occupancy and located in the same building shall be protected as required in 13-3.2.

13-1.2.7 Non-health care related occupancies classified as containing high hazard contents shall not be permitted in buildings housing health care occupanices.

13-1.3 Special Definitions.

(a) Hospitals. A building or part thereof used for the medical, psychiatric, obstetrical or surgical care, on a 24-hour basis, of four or more inpatients. Hospital, wherever used in this *Code*, shall include general hospitals, mental hospitals,tuberculosis hospitals, children's hospitals, and any such facilities providing inpatient care.

(b) Nursing Home. A building or part thereof used for the lodging, boarding and nursing care, on a 24-hour basis, of four or more persons who, because of mental or physical incapacity, may be unable to provide for their own needs and safety without the assistance of another person. Nursing home, wherever used in this *Code*, shall include nursing and convalescent homes, skilled nursing facilities, intermediate care facilities, and infirmaries in homes for the aged.

(c) Residential-Custodial Care Facility. A building, or part thereof, used for the lodging or boarding of four or more persons who are incapable of self-preservation because of age or physical or mental limitation. The following types of facilities, when accommodating persons of the above description, shall be classified as residential-custodial care facilities:

1. Nursery facilities that provide full-time care for children under 6 years of age.
2. Mentally retarded care facilities, including specialized intermediate care facilities for the mentally retarded.
3. Facilities in a home for the aging, that contain a group housing arrangement for older persons, that provide at least two meals per day and such social and personal care services need by their residents, but that do not provide

intermediate or skilled nursing care.

(4) Facilities for social rehabilitation, such as those used for the treatment of alcoholism, drug abuse, or mental health problems, that contain a group housing arrangement, and that provide at least two meals per day and personal care services for their residents, but do not provide intermediate or skilled nursing care.

Facilities housing older persons, or mental patients, including the mentally retarded, who are judged to be capable of self-preservation with minimal staff assistance in an emergency, are covered by other chapters of the *Code*. (See 13-1.1.1.6 and 13-1.1.1.9.)

Children's facilities that do not provide lodging or boarding for their occupants are classified as Child Day-Care Centers, Group Day-Care Centers, or Family Child Day-Care Homes.

(d) Supervisory Care Facility. A building or part thereof used for the lodging or boarding of four or more mental health patients who are capable of self-preservation and who require supervision and who are receiving therapy, training or other health related care and who may have imposed upon them security measures not under their control.

(c) Ambulatory Health Care Centers. A building or part thereof used to provide services or treatment to four or more patients at the same time and meeting either (1) or (2) below.

1. Those facilities which provide, on an outpatient basis, treatment for patients which would render them incapable of taking action for self-preservation under emergency conditions without assistance from others, such as hemodialysis units or freestanding emergency medical units.

2. Those facilities which provide, on an outpatient basis, surgical treatment requiring general anesthesia.

13.1.4 Classification of Occupancy. See Definitions 13-1.3.

13-1.5 Classification of Hazard of Contents. The classification of hazard of contents shall be as defined in Section 4-2.

13-1.6 Minimum Construction Requirements.

13-1.6.1 For purpose of 13-1.6, stories shall be counted starting at the primary level of exit discharge and ending at the highest occupiable level. For purposes of this section, the primary level of exit discharge of a building shall be that floor which is level with or above finished grade of the exterior wall line for 50 percent or more of its perimeter. Building levels below the primary level shall not be counted as a story in determining the height of a building.

13-1.6.2 Health care buildings of one story in height only may be of any type of construction. (See 13-3.5 for automatic extinguishment requirements.)

13-1.6.3 Health care buildings up to and including two stories in height may be constructed of Type I (443), I (332) or II (222) construction, Type II (111) construction, Type III (211) construction, Type V (111) construction, Type IV (2HH) construction, or Type II (000) construction. (See 13-3.5 for automatic extinguishment requirements.)

Exception: Any building of Type I or Type II (222 or 111) construction may include roofing systems involving combustible supports, decking, or roofing provided: (1) the roof covering meets Class C requirements in accordance with Fire Tests for Roof Coverings, NFPA 256 and (2) the roof is separate from all occupied portions of the building by a noncombustible floor assembly which includes at least 2 1/2 in. (6.35 cm) of concrete or gypsum fill. To qualify for this exception, the attic or other space so developed shall either be unoccupied or protected throughout by an approved automatic sprinkler system.

13-1.6.4 Health care buildings three stories or more in height shall be of Type I (443), I (332) or II (222) construction.

Exception No. 1: Health care buildings up to and including three stories in height may be of Type II (111) construction if protected throughout by an approved automatic sprinkler system.

Exception No. 2: Any building of Type I or Type II (222 or 111) construction may include roofing systems involving combustible supports, decking, or roofing provided: (1) the roof covering meets Class C requirements in accordance with Fire Tests for Roof Coverings, NFPA 256 and (2) the roof is separated from all occupied portions of the building by a noncombustible floor assembly which includes at least 2 1/2 in. (6.35 cm) of concrete or gypsum fill. To qualify for this exception, the attic or other space so developed shall either be unoccupied or protected throughout by an approved automatic sprinkler system.

13-1.6.5 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials.

Exception: Listed fire retardant treated wood studs may be used within non-load bearing 1-hour fire-rated partitions.

13-1.6.6 Openings for the passage of pipes or conduit in walls or partitions that are required to have fire or smoke resisting capability shall be protected in accordance with 6-2.2.8 or 6-3.6.

13-1.6.7 Firestopping. Each exterior wall of frame construction and interior stud partitions shall be firestopped so as to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor. Such firestopping shall consist of wood at least 2 in. (5.1 cm) (nominal) thick, or of suitable noncombustible material.

13-1.7 Occupant Load. The occupant load for which means of egress shall be provided for any floor shall be the maximum number of persons intended to occupy that floor, but not less than one person for each 120 sq ft (11.15 sq m) gross floor area in health care sleeping departments and not less than one person for each 240 sq ft (22.3 sq m) of gross floor area of inpatient health care treatment departments. Gross floor areas shall be measured within the exterior building walls with no deductions. (See Chapter 3.)

SECTION 13-2 MEANS OF EGRESS REQUIREMENTS

13-2.1 General. Every aisle, passageway, corridor, exit discharge, exit location and access shall be in accordance with Chapter 5.

Exception No 1: As odified in the following paragraphs:

Exception No 2: The requirements of Chapter 5 specifying net clear door width do not apply. Projections into the door opening by stops or by hinge stiles shall be permitted.

13-2.2 Types of Exits. Exits shall be restricted to the permissible types described in 13-2.2.1 through 13-2.2.7.

13-2.2.1 Doors Leading Directly Outside the Building. (See 5-2.1.)

13-2.2.2 Class A or B Interior Stairs. (See 5-2.2.)

Exception: Any existing interior stair not complying with 5-2.2 may be continued in use subject to the approval of the authority having jurisdiction.

13-2.2.3 Smokeproof Towers. (See 5-2.3.)

13-2.2.4 Outside Stairs. (See 5-2.5.)

13-2.2.5 Horizontal Exits. A horizontal exit shall be in conformance with 5-2.4, modified as below:

(a) At least 30 net sq ft (2.79 sq m) per patient in a hospital or nursing home or 15 net sq ft (1.39 sq m) per resident in a residential-custodial care facility shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas and other low hazard areas on each side of the horizontal exit. On stories not housing bed or litter patients, or in supervisory care facilities, at least 6 net sq ft (.56 sq m) per occupant shall be provided on each side of the horizontal exit for the total number of occupants in adjoining compartments.

(b) A door in a horizontal exit is not required to swing with exit travel as specified in 5-2.4.2.3.

(c) The total exit capacity of the other exits (stairs, ramps, doors leading outside the building) shall not be reduced below one-third that required for the entire area of the building.

13-2.2.6 Class A or B Ramps. (See 5-2.6.) Ramp width shall be as specified in 13-2.5.2.

13-2.2.7 Exit Passageways. (See 5-2.7.)

13-2.3 Capacity of Means of Egress. (See also 13-2.5.2.)

13-2.3.1 The capacity of any required means of egress shall be based on its width as defined in Section 5-3.

13-2.3.2 The capacity of means of egress providing travel by means of stairs shall be 22 persons per exit unit; and the capacity of means of egress providing horizontal travel (without stairs); such as doors, ramps, or horizontal exits, shall be 30 persons per unit.

Exception: The capacity of means of egress in health care occupancies protected throughout by an approved automatic sprinkler system may be increased to 35 persons per exit unit for travel by means of stairs, and to 45 persons per exit unit for horizontal travel without stairs.

13-2.4 Number of Exits

13-2.4.1 At least two exits of the types described in 13-2.2.1 through 13-2.2.7, located remotely from each other, shall be provided for each floor or fire section of the building.

13-2.4.2 At least one exit from each floor, fire section or smoke compartment shall be a door leading directly outside the building, interior stair, outside stair, smokeproof tower, ramp or exit passageway. Any fire section, floor or smoke compartment not meeting these requirements shall be considered as part of an adjoining zone. Egress shall not require return through the zone of fire origin.

13-2.5 Arrangement of Means of Egress

13-2.5.1 Every patient sleeping room shall have an exit access door leading directly to an exit access corridor.

Exception No. 1: If there is an exit door opening directly to the outside from the room at ground level.

Exception No. 2: One adjacent room, such as a sitting or anteroom, may intervene if all doors along the means of egress are equipped with nonlockable hardware other than provided in 13-2.11, and if the intervening room is not used to serve as an exit for more than eight patient sleeping beds.

Exception No. 3: Exception No. 2 above shall apply to special nursing suites permitted in 13-2.5.4 and suites in supervisory care facilities without being limited to eight beds or basinettes.

13-2.5.2 Any required aisle, corridor, or ramp shall be not less than 48 in. (121.92 cm) in clear width when serving as means of egress from patient sleeping rooms. It shall be so arranged as to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers.

13-2.5.3 Any room, and any suite of rooms as permitted in 13-2.5.1, of more than 1,000 sq ft (92.9 sq m) shall have at least two exit access doors remote from each other.

13-2.5.4 Any patient sleeping room which complies with the requirements previously set forth in this section may be subdivided with non-fire-rated, noncombustible or limited-combustible partitions, provided that the arrangement allows for direct and constant visual supervision by nursing personnel. Rooms which are so subdivided shall not exceed 5,000 sq ft (464.5 sq m).

Exception: In supervisory care facilities, such spaces continuously monitored by staff do not require visual supervision providing the space is equipped with an electrically supervised smoke detection system.

13-2.5.5 Every corridor shall provide access to at least two approved exits in accordance with Sections 5-4 and 5-5 without passing through any intervening rooms or spaces other than corridors or lobbies.

Exception: Existing dead-end corridors may be continued in use if it is not practical and feasible to alter them so that exits will be accessible in at least two different directions from all points in aisles, passageways, and corridors.

13-2.6 Measurement of Travel Distance to Exits

13-2.6.1 Travel distance shall be measured in accordance with Section 5-6.

13-2.6.2 Travel distance:

(a) Between any room door required as exit access and an exit shall not exceed 100 ft (30.48 m);

(b) Between any point in a room and an exit shall not exceed 150 ft (45.72 m);

(c) Between any point in a health care sleeping room or suite and an exit access door of that room or suite shall not exceed 50 ft (15.24 m).

Exception: The travel distance in (a) or (b) above may be increased by 50 ft (15.24 m) in buildings protected throughout by an approved automatic sprinkler system.

13-2.7 Discharge from Exits.

13-2.7.1 The exit discharge shall be arranged and marked to make clear the direction of egress. Required exit stairs that continue beyond the level of discharge shall be interrupted at the level of discharge by partitions, doors, physical barriers, or other effective means.

13-2.7.2 A maximum of 50 percent of the exits may discharge through areas on the floor of exit discharge in accordance with 5-7.2.

13-2.8 Illumination of Means of Egress

13-2.8.1 Each facility as indicated within 13-1.1.1.2 shall be provided with illumination of means of egress in accordance with Section 5-8.

13-2.9 Emergency Lighting.

13-2.9.1 Each facility as indicated within 13-1.1.1.2 shall be provided with emergency lighting in accordance with Section 5-9.

Exception: Emergency lighting of at least 1-hour duration shall be provided.

13-2.10.1 Each facility as indicated within 13-1.1.1.2 shall be provided with an exit marking in accordance with Section 5-10.

Exception: Where the line of exit travel is obvious signs may be omitted in one story buildings with an occupancy of less than 30 persons.

13-2.11 Special Features.

13-2.11.1 Locks shall not be permitted on patient sleeping room doors.

Exception No. 1: Key locking devices which restrict access to the room from the corridor may be permitted. Such devices shall not restrict egrass from the room.

Exception No. 2: Doors in homes for the aged may be lockable by the occupant, if they can be unlocked from the opposite side and keys are carried by attendants at all times. (See also 5-2.1.2.1.1 and 5-2.1.2.1.2.)

Exception No. 3: Special door locking arrangements are permitted in mental health facilities. (See 13-1.1.1.7 and 13-2.11.4.)

13-2.11.2 Doors leading directly to the outside of the building may be subject to locking from the room side.

13-2.11.3 Doors within the means of egress shall not be equipped with a latch or lock which requires the use of a key from the inside of the building. (See 5-2.1.2.)

Exception No. 1: Door locking arrangements are permitted in mental health facilities. (See 13-1.1.1.7.)

Exception No. 2: Special Locking arrangements in accordance with 5-2.1.2.1.5 are permitted on exterior doors.

13-2.11.4 The minimum width for evacuation purposes only for exit access door leaves from hospital, nursing home and residential custodial sleeping rooms, diagnostic and treatment areas, such as X-ray, surgery, or physical therapy; all door leaves between the spaces and the required exits; and all exit door leaves serving these spaces shall be at least 34 in. (86.36 cm) wide.

13-2.11.5 Any door in an exit passageway, stair enclosure, horizontal exit, a required enclosure of a hazardous area, or smoke barrier may be held open by an automatic release device which complies with 5-2.1.2.3. The following systems shall be arranged so as to initiate the closing action of all such doors by zone or throughout the entire facility:

(a) The manual alarm system required in 13-3.4 and either (b) or (c) below.

(b) A local device designed to detect smoke on either side of the opening, or

(c) A complete automatic fire extinguishing or complete automatic fire detection system.

13-2.11.6 Where doors in a stair enclosure are held open by an automatic device as permitted in 13-2.11.5, initiation of a door closing action on any level shall cause all doors at all levels in the stair enclosure to close.

SECTION 13-3 PROTECTION

13-3.1 Protection of Vertical Openings

13-3.1.1 Any stairway, ramp, elevator hoistway, light or ventilation shaft, chute, and other veritcal opening between stories shall be enclosed in accordance with Section 6-2.2 with construction having a 1-hour fire resistance rating.

Exception No. 1: Where a full enclosure of a stairway that is not a required exit is impracticable, the required enclosure may be limited to that necessary to prevent a fire originating in any story from spreading to any other story.

Exception No. 2: Stairs that do not connect to a corridor, do not connect more than two levels, and do not serve as a means of egress need not comply with these regulations.

Exception No. 3: Floor and ceiling openings for pipes or conduits when the opening around the pipes or conduits is sealed in an approved manner (See 6-2.2.8.)

13-3.1.2 A door in a stair enclosure shall be self-closing, shall normally be kept in a closed position and shall be marked in accordance with 5-10.4.2.

Exception: Doors in stair enclosures may be held open under the conditions specified by 13-2.11.5.

13-3.2 Protection from Hazards.

13-3.2.1 Any hazardous areas shall be safeguarded by fire barrier of 1-hour fire resistance rating or provided with an automatic extinguishing system in accordance with 6-4.1. Hazardous areas include, but are not restricted to, the following:

Boiler and heater rooms
Laundries
Kitchens
Handicraft shops
Employee locker rooms
Soiled linen rooms
Repair shops
Paint shops
Trash collection rooms
Gift shops
Rooms or spaces, including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
Laboratories employing quantities of flammable or combustible maerials less than that which would be considered severe.

13-3.2.2 Laboratories employing quantities of flammable, combustible, or hazardous materials which are considered as severe hazard shall be protected in accordance with Laboratories in Health-Related Institutions, NFPA 56C.

13-3.2.3 Cooking facilities shall be protected in accordance with 7-2.3.

13-3.3.1 Interior finish on walls and ceilings throughout shall be Class A or Class B, in accordance with Section 6-5.

Exception: In buildings equipped with a complete approved automatic sprinkler system, Class C interior finish may be continued in use on all walls and ceilings within rooms separated in accordance with 13-3.6 from the exit access corridors.

13-3.3.2 Newly installed interior finish in corridors and exits shall be Class I in accordance with Section 6-5. No restrictions shall apply to existing interior floor finish.

13-3.4 Detection, Alarm, and Communication Systems.

13-3.4.1 Other than as noted below, required detection and signalling devises or systems shall be in accordance with Section 7-6.

13-3.4.2 Every building shall have a manually operated fire alarm system, in accordance with Section 7-6.

13-3.4.3 Operation of any fire alarm device shall automatically, without delay, accomplish the following:

(a) General alarm indication

(b) Control functions required to be performed by that device.

Zoned, coded systems shall be permitted.

13-3.4.4 The fire alarm system shall be arranged to transmit an alarm automatically to the fire department legally committed to serve the area in which the health care facility is located, by the most direct and reliable method approved by local regulations.

13-3.4.5 Internal audible alarm devices shall be provided and shall be installed in accordance with Section 7-6.

Exception: Where visual alarm devices have been installed in patient sleeping areas, they may be accepted by the authority having jurisdiction.

13-3.4.6 An approved automatic smoke detection system shall be installed in all corridors of supervisory care facilities. Such systems shall be installed in accordance with Section 7-6 and with the applicable standards listed in Appendix B (of the Code), but in no case shall smoke detectors be spaced further apart than 30 ft (914.4 cm) on centers or more than 15 ft (457.2 cm) from any wall. All automatic smoke detection systems required by this section shall be electrically interconnected to the fire alarm system.

Exception: Where each patient sleeping room is protected by such an approved detection system and a local detector is provided at the smoke barrier and horizontal exits, such corridor systems will not be required on the patient sleeping room floors.

13-3.4.7 Any fire detection device or system required by this section shall be electrically interconnected with the fire alarm system.

13-3.5 Extinguishment Requirements.

13-3.5.1 All health care facilities shall be protected throughout by an approved automatic sprinkler system. (See 13-1.6 for construction types permitted.)

Exception: Buildings of Type I (443), I (332) or II (222) construction of any height or Type II (111) construction not over 1 story in height.

13-3.5.2 Where exceptions are stated in the provisions of the *Code* for health care occupancies protected throughout by an approved automatic sprinkler system, and where such systems are required, the systems shall be in complete accordance with Section 7-7 for systems in light hazard occupancies and shall be electrically interconnected with the fire alarm system.

13-3.5.3 The main sprinkler control valve(s) shall be electrically supervised so that at least a local alarm will sound at a constantly attended location when the valve is closed.

13-3.5.4 Sprinkler piping serving not more than six sprinklers for any isolated hazardous area may be connected directly to a domestic water supply system having a capacity sufficient to provide 0.15 gal per minute per sq ft...of floor area throughout the entire enclosed area. An indicating shut-off valve shall be installed in an accessible location between the sprinklers and the connection to the domestic water supply. New installations in existing buildings where more than two sprinklers are installed in a single area, waterflow detection shall be provided to sound the building fire alarm system in the event of sprinkler operation. (For sprinkler requirements for hazardous areas, see 13-3.2 and for sprinkler requirements for chutes, see 13-5.4.)

13-3.5.5 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 7-7.4.1.

13-3.6 Construction of Corridor Walls.

13-3.6.1 Corridors shall be separated from all other areas by partitions. Such partitions shall be continuous from the floor slab to the underside of the roof or floor slab above, through any concealed spaces such as those above the suspended ceilings, and through interstitial structural and mechanical spaces, and shall have a fire resistance rating of at least 20 minutes.

Exception No. 1: In health care occupancies protected throughout by an approved automatic sprinkler system, corridor may be separated from all other areas by non-fire-rated partitions, and where suspended ceilings are provided, the partitions may be terminated at the suspended ceiling.

Exception No. 2: Corridor partitions may terminate at ceilings which are not an integral part of a floor construction if there exists 5 ft (152.4 cm) or more of space between the top of the ceiling subsystem and the bottom of the floor or roof above, provided:

(a) The ceiling shall have been tested as a part of a fire-rated assembly in accordance with Standard Methods of Fire Tests of Building Construction and Materials, NFPA 251, for a test period of 1-hour or more, and

(b) Corridor partitions from smoketight joints with the ceilings (joint filler, if used, shall be noncombustible), and

(c) Each compartment of interstitial space which constitutes a separate smoke area is vented, in case of smoke emergency, to the outside by mechanical means having sufficient capacity to provide at least two air changes per hour, but in no case having a capacity less than 5,000 cfm, and

(d) The interstitial space shall not be used for storage, and

(e) The space shall not be used as a plenum for supple, exhaust or return air except as noted in (c).

Exception No. 3: Waiting areas may be open to the corridor, provided:

(a) Each area does not exceed 600 sq ft (55.74 sq m), and

(b) The area is located to permit direct supervision by the facility staff, and

(c) The area is arranged not to obstruct any access to required exits, and

(d) The area is equipped with an electrically supervised, automatic smoke detection system installed in accordance with 13-3.4.

Exception No. 4: Spaces other than patient sleeping rooms, treatment rooms and hazardous areas may be open to the corridor and may be unlimited in area provided:

(a) Each space is located to permit direct supervision by the facility staff, and

(b) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system installed in accordance with 13-3.4, and

(c) Each space is protected by automatic sprinklers or the furnishings and furniture in combination with all other combustibles within the area are of such a minimum quality and are so arranged that a fully developed fire is unlikely to occur, and

(d) The space is arranged not to obstruct access to required exits.

Exception No. 5: Space for doctors' and nurses' charting, communications and related clerical areas may be open to the corridor.

Exception No. 6: Corridor partitions may terminate at monolithic ceilings which are designed and constructed to resist the passage to smoke and there is a smoke-tight joint between the top of the partition and the bottom of the ceiling.

Exception No. 7: In a supervisory care facility, group meeting or multipurpose therapeutic spaces, other than hazardous areas, under continuous supervision by facility staff may be open to the corridor provided:

(a) Each area does not exceed 1,500 sq ft (139.35 sq m), and

(b) The area is located to permit direct supervision by the facility staff, and

(c) The area is arranged not to obstruct any access to required exits, and

(d) The area is equipped with an electrically supervised, automatic smoke detection system installed in accordance with 13-3.4, and

(e) Not more than one such space is permitted per smoke compartment.

13-3.6.2 Fixed wired glass vision panels shall be permitted in corridor walls provided they do not exceed 1,296 sq in. (.84 sq m) in area and are mounted in steel or other approved metal frames.

Exception: There shall be no restrictions in area and fire resistance of glass and frames in buildings protected throughout by an approved automatic sprinkler system.

13-3.6.3 Doors protecting corridor openings, in other than required enclosures of exits or hazardous areas, shall be substantial doors, such as 1 3/4 in. (4.45 cm) solid bonded core wood or of construction that will resist fire for at least 20 minutes. Doors shall be provided with latches suitable for keeping the door tightly closed and acceptable to the authority having jurisdiction. Fixed view panels of wired glass in approved steel frames, or other approved construction shown acceptable by fire test, limited to 1,296 sq in. (.84 sq m) in area, may be installed in these doors.

Exception No. 1: In buildings protected throughout by an approved automatic sprinkler system, the door construction requirements noted above are not required but the doors shall be constructed to resist the passage of smoke. Doors shall be provided with latches of a type suitable for keeping the door tightly closed and acceptable to the authority having jurisdiction.

Exception No. 2: In buildings protected throughout by an approved automatic sprinkler system, there is no restriction on the area of the vision panels in such doors, and the vision panels do not need to be wired glass, and there is no restriction in the type of frames.

Exception No. 3: Door-closing devices are not required on doors in corridor wall openings other than those serving exits or required enclosure of hazardous areas.

Exception No. 4: Doors to toilet rooms, bathrooms, shower rooms, sink closets and similar auxiliary spaces which do not contain flammable or combustible materials are exempt from these requirements.

13-3.6.4 Transfer grills, whether or not protected by fusible link-operated dampers, shall not be used in these walls or doors.

Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets and similar auxiliary spaces which do not contain flammable or combustible materials may have ventilating louvers or may be undercut.

13-3.7 Subdivision of Building Spaces.

13-3.7.1 Smoke barriers shall be provided, regardless of building construction, as follows:

(a) To divide every story, used for sleeping rooms for more than 30 health care occupants, into at least two compartments, and

(b) To limit on any story the maximum area of each smoke compartment to no more than 22,500 sq ft (2090 sq m), of which both length and width shall be no more than 150 ft (45.72 m).

Exception: Protection may be accomplished in conjunction with the provision of horizontal exits.

13-3.7.2 Smoke barriers shall be provided on stories which are usable but unoccupied.

13-3.7.3 Any required smoke barrier shall be constructed in accordance with Section 6-3 and shall have a fire resistance rating of at least 1/2 hour.

13-3.7.4 At least 30 net sq ft (2.79 sq m) per patient in a hospital or nursing home or 15 net sq ft (1.39 sq m) per resident in a residential custodial care facility shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litter patients or in supervisory care facilities at least 6 net sq ft (.56 sq m) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments.

13-3.7.5 Openings in smoke barriers shall be protected by wired glass panels in steel frames, by doors of 20-minute fire protection rating, or by 1 3/4 in. (4.45 cm) solid bonded wood core doors as a minimum.

Exception: Doors may have wired glass vision panels installed in approved metal frames not exceeding 1,296 sq in. (.84 sq m).

13-3.7.6 Doors in smoke barriers shall comply with Section 6-3 and shall be self-closing. Such doors in smoke barriers shall not be required to swing with exit travel.

Exception: Doors may be held open only if they meet the requirements of 13-2.11.5.

13-3.7.7 An approved damper to resist the passage of smoke shall be provided at each point a duct penetrates a smoke barrier required by 13-3.7.1. The damper shall close upon detection of smoke by an approved smoke detector, located within the duct. (See also Section 6-3.)

Exception No. 1: In lieu of an approved smoke detector located within the duct, ducts which penetrate smoke barriers above smoke barrier doors (required by 13-3.7.5) may have the approved damper arranged to close upon detection of smoke by the local device designed to detect smoke on either side of the smoke barrier door opening.

Exception No. 2: Dampers may be omitted in buildings equipped with an approved engineered smoke control system. The smoke control system shall respond automatically, preventing the transfer of smoke across the smoke barrier and shall be designed in accordance with Standard for the Installation of Air Conditioning and Ventilating Systems, NFPA 90A.

Exception No. 3: Dampers may be omitted where openings in ducts are limited to a single smoke compartment and the ducts are of steel construction.

13-3.8 Special Features

13-3.8.1 Every patient sleeping room shall have an outside window or outside door with light. The maximum allowable sill height shall not exceed 36 in. (91.44 cm) above the floor.

Exception No. 1: The window sill in special nursing care areas such as those housing ICU, CCU, hemodialysis, and neo-natal patients may be 60 in. (152.4 cm) above the floor.

Exception No. 2: Rooms intended for occupancy of less than 24 hours, such as those housing obstetrical labor beds, recovery beds, and observation beds in the emergency department; and newborn nurseries, need not comply with this requirement.

SECTION 13-4 SPECIAL PROVISIONS

13-4.1 Windowless Buildings. See Section 30-7 for requirements for windowless buildings.

SECTION 13-5 BUILDING SERVICES

13-5.1 Utilities. Utilities shall comply with the provisions of Section 7-1.

13-5.2 Heating, Ventilating and Air Conditioning

13-5.2.1 Heating, ventilating and air conditioning shall comply with the provisions of Section 7-2 and shall be installed in accordance with the manufacturer's specifications.

Exception: As modified in 13-5.2.2 following.

13-5.2.2 Portable space heating devices are prohibited. Any heating device other than a central heating plant shall be so designed and installed that combustible material will not be ignited by it or its appurtenances. If fuel fired, such heating devices shall be chimney or vent connected, shall take air for combustion directly from the outside, and shall be so designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.

Exception No. 1: Approved suspended unit heaters may be used in locations other then means of egress and patient sleeping areas, provided such heaters are located high enough to be out of the reach of persons using the area and provided they are equipped with the safety features called for above.

Exception No. 2: Fireplaces may be installed and used only in areas other than patient sleeping areas, provided that these areas are separated from patient sleeping spaces by construction having a 1-hour fire resistance rating and they comply with Standard for Chimneys, Fireplaces and Vents, NFPA 211. In addition thereto, the fireplace shall be equipped with a heat tempered glass, or other approved material, fireplace enclosure guaranteed against breakage up to a temperature of 650° F (343.33° C). If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure and other safety precautions may be required.

Exception No. 3: Portable space heating devices shall be permitted to be used in nonsleeping staff and employee areas when the heating elements of such a device are limited to not more than 212° F (100° C).

13-5.3 Elevators, dumbwaiters and vertical conveyors shall comply with the provisions of Section 7-4.

13-5.4 Rubbish Chutes, Incinerators and Laundry Chutes

13-5.4.1 Any existing linen and trash chute, including pneumatic rubbish and linen systems, which open directly onto any corridor shall be sealed by fire-resistive construction to prevent further use or shall be provided with a fire door assembly suitable for a Class B location and having a fire protection rating of 1 1/2 hours. All new chutes shall comply with Section 7-5.

13-5.4.2 Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection installed in accordance with Standard for the Installation of Sprinkler Systems, NFPA 13.

13-5.4.3 Any trash chute shall discharge into a trash collecting room used for no other purpose and protected in accordance with Section 6-4.

13-5.4.4 Existing flue-fed incinerators shall be sealed by fire-resistive construction to prevent further use.

CHAPTER 20 LODGING OR ROOMING HOUSES

Section 20-1 General Requirements

20-1.1 Application

20-1.1.1 This *Code* has differing requirements for the several types of residential occupancies; thus, the *Code* has several residential occupancy chapters, Chapters 16 through 23.

20-1.1.2 This chapter applies only to lodging or rooming houses providing sleeping accomodations for 15 or less persons. Lodging or rooming houses including buildings in which separate sleeping rooms are rented providing sleeping accomodations for a total of 15 or less persons on either a transient or permanent basis, with or without meals but without separate cooking facilities for individual occupants, except as provided in Chapter 22.

20-1.1.3 The requirements of this chapter are applicable to new buildings and to existing or modified buildings according to the provisions of Section 1.4 of this *Code*.

20-1.1.4 In addition to the following provisions, every lodging or rooming house shall comply with the minimum requirements for one- and two-family dwellings.

20-1.2 Mixed Occupancies.

20-1.2.1 Where another type of occupancy occurs in the same building as a residential occupancy, the requirements of 1-4.5 of this *Code* shall be applicable.

20-1.2.2 For requirements on mixed mercantile and residential occupancies, see 24-1.2 or 25-1.2.

20-1.3. Definitions.

20-1.3.1 Terms applicable to this chapter are defined in Chapter 3 of this *Code;* where necessary, other terms will be defined in the text as they may

20-1.4 Classification of Occupancy. (See 20-1.1.2)

20-1.5 Classification of Hazard of Contents.

20-1.5.1* Building contents shall be classified according to the provisions 4-2.1 of this *Code*. For design of sprinkler systems, the classification of contents in Standard for the Installation of Sprinkler Systems, NFPA 13 shall apply.

20-1.6 Minimum Construction Requirements. No special requirements.

20-1.7 Occupant Load. (See 20-1.1.2)

Section 20-2 Means of Escape

20-2.1 Number and Means of Escape.

20-2.1.1 Every sleeping room above or below the level of exit discharge shall have access to two separate means of escape one of which shall be either an enclosed interior stairway, an exterior stairway, or a horizontal exit.

Exception: In existing buildings a fire escape stair is acceptable.

20-2.1.2 At least one means of escape shall be located to provide a safe path of travel to the outside of the building without traversing any corridor or space exposed to an unprotected vertical opening.

Exception: Unprotected vertical openings may be permitted in buildings three stories or less in height protected throughout by an approved sprinkler system designed in accordance with Section 7-7 and Standard for the Installation of Sprinkler Systems, NFPA 13, or Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Mobile Homes, NFPA 13D.

20-2.1.3 Every sleeping room located on the level of exit discharge shall have access to two separate means of escape, one of which may be an operable window. (See Section 22-2)

Exception: One-story buildings with rooms having direct access to the exterior at grade.

20-2.2 **Winders** in accordance with 5-2.2.2.4 are permitted.

20-2.3* No door in any means of egress shall be locked against egress when the building is occupied (see 5-2.1.2)

Section 20-3 Protection

20-3.1 Alarm System.

20-3.1.1 A manual fire alarm system shall be provided in accordance with section 7-6.

20-3.2 Detection System.

20-3.2.1 Approved smoke detectors, meeting the requirements of Standard for Household Fire Warning Equipment, NFPA 74, and powered by the house electrical service, shall be installed on each floor level including basements and excluding crawl spaces and unfinished attics. When activated, the detectors shall initiate an alarm which shall be audible in all sleeping areas.

Section 20-4 Special Provisions

Section 20-5 Building Services

CHAPTER 22 ONE- AND TWO-FAMILY DWELLINGS

Section 22-1 General Requirements

22-1.1 Application.

22-1.1.1 This chapter establishes life safety requirement for all one- and two-family private dwellings. One- and two-family dwellings include buildings containing not more than two dwelling units in which each living unit is occupied by members of a single family with no more than three outsiders, if any, accomodated in rented rooms.

22-1.1.2 The requirements of this chapter are applicable to new buildings, and to existing or modified buildings according to the provisions of Section 1-4 of this *Code*.

22-1.2 Mixed Occupancies.

22-1.2.1 Where another type of occupancy occurs in the same building as a residential occupancy, the requirements of 1-4.5 of this *Code* shall be applicable.

22-1.2.2 For requirements on mixed mercantile and residential occupancies, see 24-1.2 or 25-1.2.

22-1.3 Definitions

22-1.3.1 Terms applicable to this chapter are defined in Chapter 3 of this *Code*; where necessary, other terms will be defined in the text as they may occur.

22-1.4 Classification of Occupancy (See 22-1.1.1.)

22-1.5 Classification of Hazard of Contents.

22-1.5.1* Building contents shall be classified according to the provisions of 4-2.1 of this *Code*. For design of sprinkler systems, the classification of contents in Standard for the Installation of Sprinkler System, NFPA 12 shall apply.

22-1.6 Minimum Construction Requirements. No special requirements.

22-1.7 Occupant Load.

Section 22-2* Means of Escape Requirements

22-2.1 Number of Exits

22.2.1.1 In any dwelling of more than two rooms, every bedroom and living room area shall have at least two means of escape at least one of which shall be a door or stairway providing a means of unobstructed travel to the outside of the building at street or ground level. No bedroom or living room shall be accessible by only a ladder or folding stairs, or through a trap door.

22-2.2 Type of Second Means of Escape.

22-2.2.1* The second means of escape shall be either:

(a) A door or stairway providing a means of unobstructed travel to the outside of the building at street or ground level, or

(b) An outside window operable from the inside without the use of tools and providing a clear opening of not less than 20 in. (50.8 cm) in width, 24 in. (60.96 cm) in height, and 5.7 sq ft (.53 sq m) in area. The bottom of the opening shall not be more than 44 in (111.76 cm) above the floor.

Exception No. 1: If the room has a door leading directly outside of the building to grade, a second means of escape shall not be required.

Exception No. 2: If buildings are protected throughout by an approved automatic sprinkler system installed in accordance with Standard for the Installation of Sprinkler Systems, NFPA 13, or Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Mobile Homes, NFPA 13D, a second means of escape shall not be required.

22.2.3 Arrangement of Means of Egress

22.2.3.1 No required path of travel to the outside from any room shall be through another room or apartment not under the immediate control of the occupant of the first room or his family, nor through a bathroom or other space subject to locking.

22-2.4 Doors

22-2.4.1 No door in the path of travel of a means of escape shall be less than 28 in. (71.12 cm) wide.

Exception: Bathroom doors may be 24 in. (60.96 cm) wide.

22-2.4.2 Every closet door latch shall be such that children can open the door from inside the closet.

22-2.4.3 Every bathroom door lock shall be designed to permit the opening of the locked door from the outside in an emergency.

22-2.4.4 Exterior exit doors may be swinging or sliding and are exempt from the requirements of 5-2.1.1.4.1.

22-2.5 Vertical Means of Escape, Stairs.

22-2.5.1 The width, risers, and treads of every stair shall comply with the minimum requirements for stairs, as described in 5-2.2. Winders and spiral stairs in accordance with Chapter 5 are permitted within a single living unit.

22-2.6* No door in any means of egress shall be locked against egress when the building is occupied (see 5-2.1.2)

Section 22-3 Protection

22-3.1 Interior Finish

22-3.1.1 Interior finish on walls and ceilings of occupied spaces shall be Class A, B, or C as defined in Section 6-5.

22-3.1.2 Interior Floor Finish. No requirements.

22-3.2 Detection and Alarm.

22-3-2.1* At least one approved smoke detector powered by the house electric service shall be installed in an approved manner in every dwelling unit. When activated, the detector shall initiate an alarm which is audible in the sleeping rooms. For location of single station detectors, See Chapter 22.

Exception: In existing construction approved smoke detectors powered by batteries may be used.

Section 22-4 (Reserved)

Section 22-5 Building Services

22-5.1 Heating Equipment

22-5.1.1 No stove or combustion heater shall be so located as to block escape in case of fire arising from malfunctioning of the stove or heater.

APPENDIX C

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ALABAMA

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Tuscaloosa, AL 35401

Alabama DD Planning Council
200 Interstate Park Dr.
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Montgomery, AL 36193-5001

Division of Mental Retardation
Alabama Department of Mental Health
135 South Union Str.
Montgomery, AL 36130

ALASKA

P&A for the Developmentally
Disabled, Inc.
325 E. 3rd Ave., 2nd Floor
Anchorage, AK 99501

Governor's Council for the
Handicapped and Gifted
600 University Ave., Suite C
Fairbanks, AK 99701

Department of Health and
Social Services
Pouch H-04
Juneau, AK 99801

ARIZONA

Arizona Center for Law in the
Public Interest
112 North Fifth Ave.
Phoenix, AZ 85003

Executive Director
Governor's Council on DD
1717 West Jefferson Str., Rm. 112
Phoenix, AZ 85005

Division of Developmental
Disabilities
State Department of Economic
Security
1717 West Jefferson Str.
Phoenix, AZ 85005

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12th & Marshall Streets
Little Rock, AR 72202

Governor's DD Planning Council
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Little Rock, AR 72201

Department of Human Services
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1507 21st Str., Room 320
Sacramento, CA 95816

Health and Welfare Agency
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Sacramento, CA 95814

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1060 Bannock Str., Suite 316
Denver, CO 80204

Colorado DD Council
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Denver, CO 80236

Department of Institutions
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401 Trumbull Str.
Hartford, CT 06103

Department of Mental Retardation
DD Office
342 North Main
West Hartford, CT 06117

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913 Washington Str.
Wilmington, DE 19801

William State Service Center
DD Council
P.O. Box 1401
Dover, DE 19901

DD State Administering Agency
c/o Department of Health &
Social Services
Delaware State Hospital
New Castle, DE 19720

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Information Center for Handicapped
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605 G Str., N.W.
Washington, D.C. 20001

D.C. DD Council
614 H Str., N.W.
Room 703
Washington, D.C. 20002

Office of Social Services
Planning & Development
Randall School
1st and I Str., S.W.
Washington, D.C. 20024

FLORIDA

Governor's Commission on
Advocacy for Persons with DD
Office of the Governor
Tallahassee, FL 32301

DD Department of Health &
Rehabilitative Services
Florida DD Planning Council
1323 Winewood Blvd.
Bldg. 1, Room 309
Tallahassee, FL 32301

Department of Health &
Rehabilitative Services
1311 Winewood Blvd.
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1447 Peachtree Str., N.E.
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Georgia Council on DD
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Department of Human Resources
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Idaho State Council on DD
450 West State Str.
Boise, ID 83720

Division of Community Rehabilitation
Department of Health & Welfare
Statehouse Mail
Boise, ID 83720

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Chicago, IL 60601

Governor's Planning Council on DD
222 South College
Springfield, IL 62706

Department of Mental Health and
Developmental Disabilities
160 North LaSalle Str.
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Indiana P&A Service Commission for
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IN DD Advisory Council
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Division of Mental Retardation &
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Michigan State Planning Council for DD
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Department of Mental Health
Lewis-Cass Bldg.
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550 Cedar Str.
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101 Capitol Square Bldg.
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Rehabilitation Division
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99 Washington Ave.
Albany, NY 12210

Bureau of DD
New York State Advisory Council
on Mental Retardation & DD
44 Holland Ave.
Albany, NY 12229

Office of Mental Retardation
and Developmental Disabilities
44 Holland Ave.
Albany, NY 12229

NORTH CAROLINA

Governor's Advocacy Council
for Persons with Disabilities
112 West Lanes Str.
Raleigh, NC 27603

Division of Plans & Operations
DD Section
325 North Salisbury Str., Rm. 402
Albemarle Bldg.
Raleigh, NC 27611

NORTH DAKOTA

P&A Project for the DD
Governor's Council on Human Resources
State Capitol Annex, 1st Floor
Bismarck, ND 58505

Department of Human Services
DD Division
State Capitol
Bismarck, ND 58505

OHIO

Ohio Legal Rights Service
8 East Long Str.
6th Floor
Columbus, OH 43215

Ohio Department of Mental Retardation
and Developmental Disabilities
30 East Broad Str.
State Office Towers
Columbus, OH 43215

OKLAHOMA

P&A Agency for DD
9726 East 42nd Str.
Osage Bldg., Rm. 133
Tulsa, OK 74145

Department of Human Services
Division of Planning & Resources
Development
P.O. Box 2535
Oklahoma City, OK 73115

OREGON

Oregon DD Advocacy Center
621 S.W. Morrison, Rm. 519
Portland, OR 97205

Mental Retardation Services and
Developmental Disabilities
Mental Health Division
2575 Bittern Str., N.E.
Salem, OR 97310

PENNSYLVANIA

DD Advocacy Network, Inc.
3540 N. Progress Ave.
Harrisburg, PA 17110

Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17120

PUERTO RICO

P&A
Puerto Rico Department of Consumer
Affairs
Minillas Governmental Center
North Bldg.
P.O. Box 41059 Minillas Station
Santurce, PR 00904

Secretary of Health
Puerto Rico Department of Health
Box CH 11321
Caparra Heights Station
Santurce, PR 00922

RHODE ISLAND

Rhode Island P&A System, Inc.
70 South Main Str.
Providence, RI 02903

DD Council
600 New London Ave.
Cranston, RI 02920

Department of Mental Health,
Retardation and Hospitals
600 New London Ave.
Cranston, RI 02920

SOUTH CAROLINA

South Carolina P&A System for
the Handicapped, Inc.
2360 a-Two Notch Road
Columbia, SC 29204

DD Council, Health and Human
Services
1205 Pendelton Str., Rm. 408
Edgar Brown Bldg.
Columbia, SC 29201

Division of Health and Human
Services
1205 Pendelton Str.
Edgar Brown Bldg., 4th Floor
Columbia, SC 29201

SOUTH DAKOTA

South Dakota Advocacy Project, Inc.
111 West Capitol Ave.
Pierre, SD 57501

Office of DD
State Office, Richard F. Kneip Bldg.
Pierre, SD 57501

Department of Social Services
State Office, Richard F. Kneip Bldg.
Pierre, SD 57501

TENNESSEE

Director of Advocacy
Tennessee State Planning Office
505 Deadrick Str.
Suite 1800
James K. Pope Bldg.
Nashville, TN 37219

DD Program
Department of MH/MR
505 Deadrick Str., 4th Floor
James K. Polk Bldg.
Nashville, TN 37219

TEXAS

Advocacy, Inc.
5555 N. Lamar Str., Suite K-109
Austin, TX 78711

DD Council
P.O. Box 12668 Capitol Station
Austin, TX 78711

Division of Planning & Resources
Development
Texas Department of MH/MR
Austin, TX 78711

UTAH

Legal Center for the Handicapped
455 East 400 South, Suite 300
Salt Lake City, UT 84111

Council for Handicapped and
DD Persons
P.O. Box 11356
Salt Lake City, UT 84147

Department of Social Services
150 West North Temple, Rm. 310
Salt Lake City, UT 84110

VERMONT

Vermont DD Law Project
180 Church Str.
Old Courthouse
Burlington, VT 05401

Vermont DD Council
Waterbury Office Complex
103 South Main Str.
Waterbury, VT 05676

Agency of Human Services
103 South Main Str.
Waterbury, VT 05676

VIRGIN ISLANDS

Committee on Advocacy for the
DD, Inc.
P.O. Box 734
Frederiksted, St. Croix
U.S. Virgin Islands 00840

Virgin Islands DD Council,
Division MCH and CC
P.O. Box 520
Christiansted, St. Croix
U.S. Virgin Islands 00820

Virgin Islands Commission on the
Handicapped
P.O. Box 8298
St. Thomas, VI 00801

VIRGINIA

State P&A Office
9th Str. Office Bldg., Suite 100
Richmond, VA 23219

Department of MH/MR
DD Programs
P.O. Box 1797
109 Governor Str.
Richmond, VA 23214

WASHINGTON

Troubleshooters Office
1600 West Armory Way
Seattle, WA 98119

Washington State DD Planning
Council
Mail Stop PJ-11
Olympia, WA 98504

Department of Social & Health
Services
Division of DD
Mail Stop OB42C
Olympia, WA 98504

WEST VIRGINIA

West Virginia Advocates for the DD, Inc.
1021 Quarrier Str., Suite 411
Charleston, WV 25301

DD Services
Division of Behavioral Health Services
1800 Washington Str., East
Charleston, WV 25305

West Virginia Department of Health
State Capitol
Charleston, W.V. 25305

WISCONSIN

Wisconsin Coalition for Advocacy, Inc.
30 W. Mifflin, Suite 508
Madison, WI 53703

Council on DD, State of Wisconsin
1 West Wilson Str., Rm. 490
Madison, WI 53702

Bureau of DD
Wisconsin Department of
Health and Social Services
1 West Wilson Str., Rm. 540
Madison, WI 53702

WYOMING

DD P&A System, Inc.
508 Hynds Bldg.
Cheyenne, WY 82001

State of Wyoming
Council on DD
P.O. Box 1205
Cheyenne, WY 82001

DD State Program Manager
Division of Community Programs
Halfway Bldg. - 4th Floor
Cheyenne, WY 82002